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Moving Forward: Making Changes - An Evaluation of a Group-based Treatment Programme for Sex Offenders

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MOVING FORWARD: MAKING CHANGES – AN EVALUATION OF A GROUP-BASED TREATMENT PROGRAMME FOR SEX OFFENDERS

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All analysis and interpretation in this report is the responsibility of the authors.

Rachel Ormston & Ciaran Mullholland

Key findings and policy messages

Programme outcomes and improving impact

- There are significant limitations to the data available to quantify the impact of MF:MC. In particular, the lack of a control group means it is not possible to conclusively attribute any changes observed to MF:MC, while staff raised concerns about inter-rater reliability and the validity of some outcome measures.
- However, the monitoring data does indicate a number of positive changes among participants (though these cannot be conclusively attributed to MF:MC), including:
    - A reduction in risk scores over the course of the programme, and
    - Positive changes in scores measuring a range of psychological traits potentially associated with risk of re-offending.
- Overall, staff who contributed to this research felt that, in comparison with previous sex offender interventions, MF:MC had a 'better chance' of being effective as they viewed its overall design as being more evidence-based. While this evaluation cannot robustly assess whether every element of MF:MC's design is best practice, in general, the programme design appears to be informed by current best evidence on 'what works' in terms of appropriate treatment targets and approaches to working with sex offenders.
- However, while staff and stakeholders gave examples where they believed MF:MC had impacted positively on participants, there was also a strong feeling among staff that it was very difficult for the current programme to fully meet the diverse presenting needs of all participants.
- Interviews for this evaluation (particularly with Treatment Managers) identified a range of suggestions for improvements aimed at enhancing MF:MC's impact. In addition to the general resourcing issues, discussed above, these included:
    - providing more external expertise to support delivery
    - assigning national leads on specific approaches and issues to ensure the programme is kept continually up to date in terms of best practice
    - providing guidance on 'over-treatment' (where offenders have attended programmes numerous times with limited evidence of progress), and
    - considering the feasibility of establishing separate groups for men with lower cognitive functioning.

Improving programme delivery

- Overall, MF:MC is being delivered broadly in line with programme design with respect to: length of group sessions; group size; staff roles; staff participation in mandatory MF:MC training; and Practitioner supervision and support.
- However, the evaluation identifies a number of concerns around staff resourcing. Most community teams are currently unable to deliver MF:MC at the recommended intensity due to staffing constraints. Both Community and Prison-based Treatment Managers identified significant challenges covering leave or finding time for staff development within current resourcing. The role of psychological support for delivery within the community also needs to be clarified, and any inconsistencies in access to such resource addressed.

- While overall staff who contributed to the research felt the programme included the key elements of an effective intervention, the Programme Manual was viewed as 'a little vague'. There is also a lack of clarity about the level of deviation from the manuals that is permissible: in practice, sites were adapting content and delivery in a range of ways. While these adaptations were aimed at improving delivery, they introduce scope for inadvertent deviation from the programme design. Findings suggest that the MF:MC manuals should be reviewed, taking account of the various issues and suggestions for improvement identified in this report.
- Alongside this review, consideration should be given to developing an MF:MC 'knowledge hub', where additional (approved) materials to support delivery can be shared and added to in the light of emerging evidence on 'what works' in treating sex offenders.
- While MF:MC appears, for the most part, to be successfully targeting men rated as 'high' or 'moderate' risk, some concerns were raised over whether the current assessment process is always identifying those most suited to the programme. Guidance on assessing internet offenders and deniers for MF:MC in particular should be reviewed and updated in the light of new and emerging evidence on managing and treating these groups.
- Sites varied in whether they offered ongoing support to participants after the group stage of the programme. This suggests that guidance on ending the programme should be clear, and resourcing sufficient to ensure a consistent and appropriate approach to post-programme support.

Improving monitoring and future evaluation

- The monitoring data currently available for MF:MC contains some significant weaknesses in terms of the robustness of the outcome measures included, the perceived usability of the IT system for recording key data, and the timeliness of data collection and entry. Suggestions for improvement include:
    - A systematic review of the outcome measures included within MF:MC, taking account of concerns raised in this evaluation about: the utility and appropriateness of the current psychometric battery; the reliance on self-reported data; and completion of the 'significant others' questionnaire.
    - Considering whether any further guidance and training is required around the completion of SA07 for MF:MC specifically, given the concerns about inter-rater reliability and accuracy raised by interviewees.
    - Reviewing the structure and content of the MF:MC IT system with a view to simplifying data entry and clarifying data outputs, and enhancing data usability for both evaluators and MF:MC teams.
- Any changes resulting from this review process should be supported by refreshed guidance and training on how monitoring data should be entered and used by MF:MC teams and by the Scottish Government, SPS and any external evaluators.
- In addition to reviewing and improving the current monitoring dataset, consideration needs to be given to how longer-term outcomes can be monitored, and to whether/how a control group for MF:MC can be established. Given the relative dearth of robust evidence on the effectiveness of sex offender interventions in general, there is a clear argument for assessing the feasibility of a longer-term experimental or quasi-experimental evaluation of MF:MC. However, an experimental approach would require sufficently large sample sizes to be robust. Men would have to be randomly assigned

into the programme or into a control group. Alternatively, a large matched sample of offenders who were not on the programme would have to be identified. Both approaches would be challenging to implement in practice.

1. Introduction and background

1.1 The management of sex offenders in Scotland

Overall, there have been substantial reductions in rates of recorded crime in Scotland, including violent crime, in recent years. However, recorded sexual crime has been on a long-term upward trend since the 1970s. The increase is particularly marked from 2010-11 onwards, with a 47% increase between 2011-12 and 2016-17. There are likely to be a variety of reasons for this increase in both recorded sexual crimes and in the number of Registered Sex Offenders (RSOs) in Scotland (and England). Police Scotland have indicated that increased reporting, including reporting of historic sexual offences and online child sexual abuse, may be in part responsible for this trend (Scottish Government, 2017b). The implementation of the Sexual Offence (Scotland) Act 2009 is also a significant factor. This created new statutory offences for rape, sexual assault, coercion and new categories of 'other sexual crimes' such as coercing a person to look at a sexual image, which might previously have been prosecuted using common law offences and would not, therefore, have been capture in recorded sexual offence data.

RSOs in Scotland are managed via Multi-Agency Public Protection Arrangements (MAPPA). These arrangements bring together the Police, Scottish Prison Service (SPS), Health and Local Authorities to assess and manage the risk RSOs and other serious offenders pose. MAPPA is supported by the Violent and Sex Offender Register (ViSOR), a national IT system to facilitate inter-agency communication and ensure critical information about offenders is shared. Police Scotland also have Offender Management Units in each of the 13 territorial Divisions, with specially trained staff dedicated to the management of RSOs, restricted patients and serious and violent offenders.

The Scottish Government's justice strategy (2012) has a strong focus on reducing reoffending and rehabilitating offenders, at the same time as protecting the public. This includes those convicted of sexual offences. Moving Forward: Making Changes (MF:MC) is an intensive treatment programme for sex offenders which aims to "reduce the re-offending of men convicted of sexual offences and increase their opportunities and capacities for meeting needs by non-offending means" (MF:MC Management Manual, 2014: 6).

1.2 Moving Forward: Making Changes

MF:MC was designed by the Scottish Prison Service and the Community Justice Operational Practice Unit of the Scottish Government. It was introduced in Scotland in 2014, following accreditation by the Scottish Advisory Panel on Offender Rehabilitation (SAPOR). In line with evidence that intervention intensity ought to be linked to risk level (e.g. Lovins et al, 2009), it is aimed at adult (18 and over) male sexual offenders assessed as medium-high risk (via the Stable 2007 tool[1]). Eligibility is based on risk-level rather than offence type – men who have offended against children and against adult women are both eligible, as are those who have committed internet offences (although a slightly different assessment approach is recommended for this group). Implementation and delivery of

[1] 'Stable 2007' is part of the 'Stable and Acute 2007' (SA07) assessment tool for measuring dynamic risk factors for sexual offending recidivism – that is, factors which may be amenable to change (as distinct from 'static risk factors', which are relatively immune to change). 'Stable' factors are personal skills deficits or behaviours that may be addressed through treatment and supervision (see RMA, 2013).

MF:MC is supported by a set of manuals, covering the programme theory, structure, content, management requirements, and framework for collecting data for evaluation.

1.2.1 Core principles of the programme

MF:MC is rooted in the 'Good Lives Model' (GLM) for offender rehabilitation. The GLM assumes that everyone wants certain primary goods in their life but that, for offenders, this desire manifests itself in harmful ways due to a range of deficits in the offender and/or their environment. For example, a paedophile's preference to identify with children rather than adults is a distorted expression of the general desire for 'relatedness'. The programme puts a strong emphasis on helping people to understand themselves and their behaviours from a different perspective, to help them achieve common goals in a more 'pro-social' manner. As the theory manual puts it, the programme aims to "assist individuals to identify what their valued primary goals are, how they have tried to achieve them in the past, and how they could develop ways of achieving them in the future in a way that does not harm others" (2014: 16).

The GLM approach was introduced to address some of the perceived limitations of basing interventions solely on 'Risk-Needs-Responsivity' principles – namely that a risk-management approach did not address offender motivation to participate or provide an incentive to change (Fyfe, 2015). However, while the GLM approach provides the theoretical framework for MF:MC, the programme also draws on a wide range of treatment techniques and approaches to achieve its aim, including: Cognitive Behavioural Therapy (CBT), Schema-focused work; mindfulness; motivational techniques; and behaviour modification.

1.2.2 How MFMC is delivered

MF:MC is designed to be delivered in a group format, although it can also be delivered 1:1 or 2:1. It is based on '**rolling groups**' – men join the group at different times and can be at different stages of the programme at the same time. Men's individual programmes are structured around a number of modules and 'assignments', which they complete outside of the group and then present for discussion at an agreed group session. Different group members may be working on different assignments at the same time, but all contribute to group discussion and feedback on assignments – a feature intended to provide opportunities for 'vicarious learning'.

The programme is designed to be **responsive to individual needs** – while all men complete a number of 'essential' modules, 'optional' modules will be linked to individual treatment needs identified by the MF:MC team. The modules are linked directly to the Stable 2007 dynamic risk factors, and a small number of additional risk factors believed to be associated with sexual offending. There is **no pre-determined timescale for completion** – those with greater treatment needs (who are assigned more optional modules) will be likely to spend longer on the programme. The rolling group format distinguishes MF:MC from previous sex offender treatment programmes like the Community Sex Offender Groupwork Programme (CSOGP), which followed a more fixed structure (RMA, 2016a).

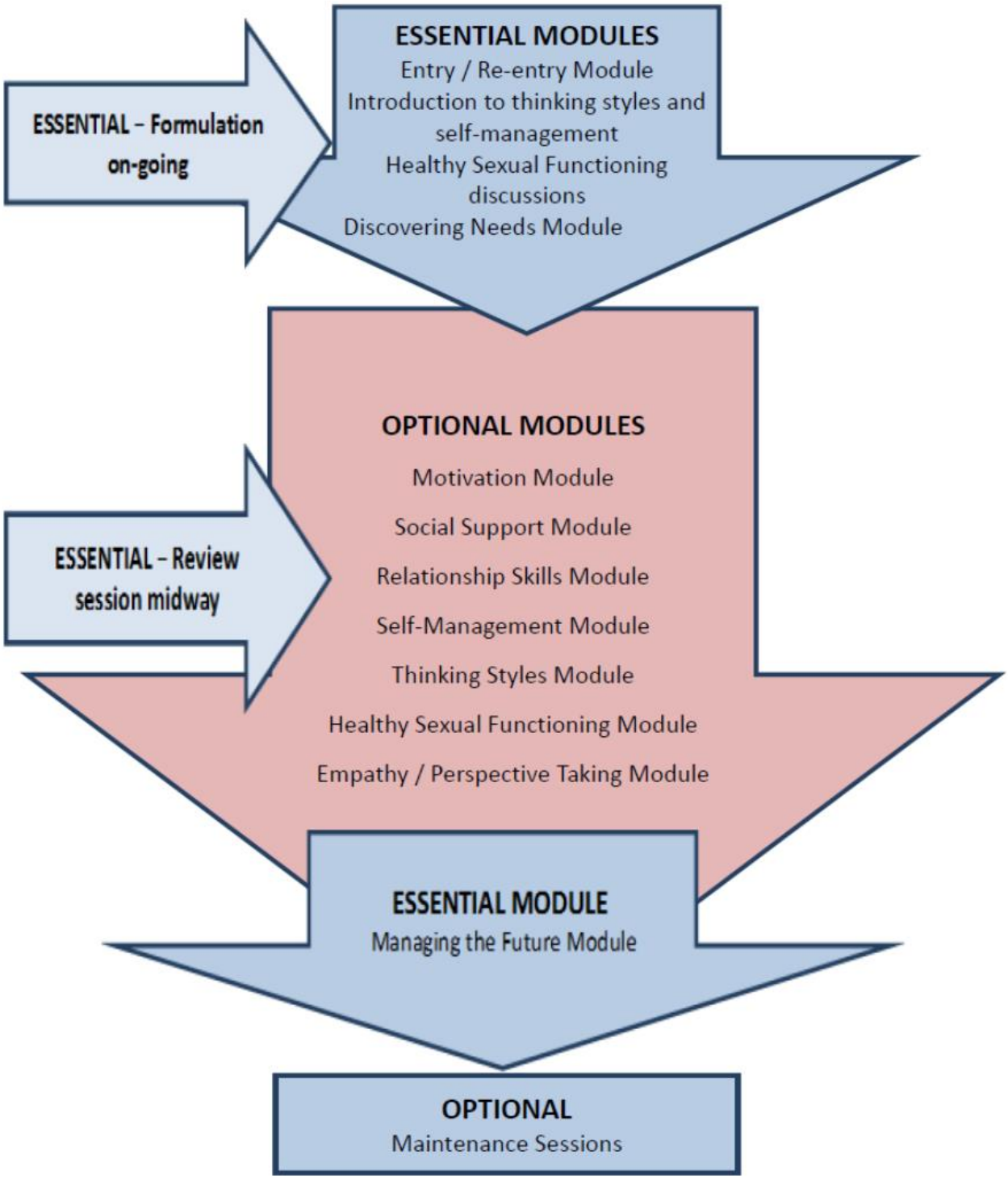
MF:MC is delivered in **both custodial settings** (currently in 4 prisons across Scotland) **and in the community** (currently 11 sites). In prison, the programme is delivered by psychologists and trainee forensic psychologists and by specially trained prison officers. In the community, it is delivered by Criminal Justice Social Work staff. MF:MC teams in each case consist of:

- one or more **Treatment Managers**, who have responsibility for ensuring the programme is delivered in accordance with its design, that participants are appropriately assessed and selected, and that staff are supported and developed
- a number of **Practitioners**, who are responsible for facilitating group or 2:1 sessions. Practitioners are assessed as 'Level 1' or 'Level 2' based on assessment of their competency levels at initial MF:MC training, or at subsequent 'transition' training after delivery of the programme for a period of time.

RSOs who are participating in MF:MC in the community will also have an assigned '**Case Manager**', a Criminal Justice Social Worker who is responsible for managing their case. The Case Manager will be involved in delivering pre-programme content to men before they join a group, and in discussing their progress throughout their time on MF:MC.

Figure 1.1, below, shows the overall structure of the programme and the essential and optional modules included.

Figure 1.1 MF:MC programme structure (from the MF:MC Theory Manual)



1.3 Evaluation aims

The Scottish Government commissioned Ipsos MORI Scotland to conduct an evaluation of MF:MC to inform considerations on SAPOR's reaccreditation of the programme in 2018, to provide evidence for policy and practice to inform future improvement, and to identify (as far as is possible) potential emerging outcomes for participants. The evaluation is intended to address three main questions:

1. How does the programme work in practice, from referral to exit, and to what extent does the programme follow the manuals? Is programme integrity maintained?
2. Are there difficulties with delivering any aspects of the programme and are there improvements that could be made?
3. What are the main outcome measures and to what extent have outcomes been realised?

1.4 Evaluation design

The evaluation adopted a mixed method design, drawing on a variety of sources of evidence to answer the questions above, including:

- Quantitative analysis of data routinely entered into the MF:MC IT system
- Qualitative interviews with:
    - 19 participants across 5 case study sites (2 custody and 3 community)
    - 18 Treatment Managers across the 15 sites[2]
    - 4 Case Managers
    - 3 stakeholders from Police Scotland and 1 psychologist working with community-based MF:MC teams.
- A half-day workshop with 23 Practitioners from 12 MF:MC sites.[3]

1.5 Challenges and limitations

In this section, we highlight the key challenges and limitations that apply to this evaluation. When presenting our findings in the remainder of this report, we have tried to strike a balance between drawing out evidence that points to areas that appear to be effective or in need of improvement, while at the same time reminding the reader of the various limitations that apply to the conclusions that can be drawn.

1.5.1 Lack of a control group

The most reliable way of establishing any intervention's impact is to compare outcomes for participants with outcomes for similar individuals who did not go through the intervention, ideally with random allocation to a sufficiently large 'treatment' or 'control' group. However, this was not considered to be an option for evaluating MF:MC at this point (and would not have been feasible within the timescale for reporting to inform SAPOR's reaccreditation decision). In the absence of a control group, any observed changes in participant outcomes cannot be conclusively attributed to MF:MC – it is possible that such changes would have occurred in the absence of the intervention.

[2] Including one partial interview, which could not be rearranged within the fieldwork period.

[3] All sites were invited to send attendees, but 3 were unable to do so on the day.

Another, related, challenge is separating the impact of MF:MC from that of other elements of the wider MAPPA system for supervising sex offenders in Scotland. In the absence of a control group who have not attended MF:MC, but are otherwise treated identically, isolating the precise impact of MF:MC is not possible. However, it should be noted again that an experimental approach would be challenging to implement in practice. It would require sufficently large sample sizes and men would have to be randomly assigned into the programme or into a control group which could raise both practical and ethical issues. Alternatively, a large matched sample of offenders (for example, who have similar offending histories, sentence lengths, needs and levels of risk) but who were not on the programme would have to be identified as a comparison group.

1.5.2 Timeframe for evaluating intervention impact

Delivery of MF:MC only started in 2014. As noted above, there is no fixed timeframe for participation, but men can be on the programme for relatively long periods. As such, at the time of writing there are still only relatively small numbers of men who have fully completed MF:MC. But perhaps more importantly in terms of assessing impact, all the impact data available for this evaluation relates to the period immediately post-programme. As such, this report is only able to consider short-term outcomes from the programme.

1.5.3 Issues relating to the content and completeness of monitoring data

Quantitative data was provided to the evaluation team from the MF:MC IT system from 2014 to September 2017 by each community site, and by SPS for all 4 prisons delivering MF:MC. However, Treatment Managers and Practitioners have highlighted a number of perceived limitations relating to the content, structure and completeness of this data. The specific issues raised are discussed further in relevant sections of chapters 2-4, but they have implications for:

- The accuracy of the data in terms of identifying how many men have completed MF:MC
- The validity and reliability of some of the data intended as outcome measures – particularly the eight psychometric scales included.

1.5.4 Limitations on interview coverage

The evaluation included interviews with Treatment Managers from every site and practitioners from 12 of 15 sites contributed to the workshop. However, it was not possible within the evaluation timescale or resources to interview men participating in MF:MC in every site. As such, there may be important variations in participants' experiences of MF:MC that are not captured here. In addition, the evaluation team were only able to speak to a very limited number of stakeholders within the available time and resources. Stakeholders from other areas, or from other backgrounds may have had different perspectives on the programme.

Men who had participated in MF:MC were recruited via MF:MC teams. While every effort was made to ensure that they did not 'cherry pick' those participants likely to be most positive about the programme, it is impossible to rule out any element of this having occurred. Moreover, participants who were less engaged with MF:MC are also less likely to be willing to engage with an evaluation interview. As such, interviews with participants are likely to be skewed towards those who were more engaged with MF:MC (although the sample did include a number of men who stated they had not been enthusiastic about taking part at the outset).

1.6 Report conventions and structure

1.6.1 Report conventions

MF:MC participants, staff and stakeholders were interviewed for this evaluation using a qualitative approach. Qualitative samples are generally small, and are designed to ensure a range of different views and experiences are captured. It is not appropriate given the number of interviews conducted to draw conclusions from qualitative data about the prevalence of particular views or experiences. As such, quantifying language, such as '*all'*, '*most'* or '*a few*' is avoided as far as possible when discussing qualitative findings.

In order to protect anonymity, participants in MF:MC are identified using anonymous reference numbers only, while quotes from staff are not attributed to specific sites (given the small numbers of staff employed in each site, a job title in combination with the site name could easily be identifying).

Finally, the evaluation was **not** designed to assess differences in success or impact between sites, nor to compare impact between SPS and community-based sites. Such comparisons are highly problematic, given that we are not able to control for external factors that might impact on 'success' in different sites (for example, the profile of participants will inevitably differ substantially between SPS and community-based sites). Evidence of perceived impact is therefore generally discussed in relation to MF:MC as a whole. However, the report does include some summary information about the overall numbers of participants across different sites and some discussion of variations in practice between sites.

1.6.2 Report structure

The remainder of this report is structured as follows:

- Chapter 2 describes the **operation** of the MF:MC programme in practice, assessing **integrity** and **consistency** of delivery in key areas
- Chapter 3 examines **participation** in MF:MC, including the operation of the **assessment** process, numbers participating, **attrition**, and the level and nature of **engagement** with the programme
- Chapter 4 considers **programme outcomes**. As described above, it is not possible to establish conclusive impacts without a control group. However, the report discusses the available evidence on **shifts in risk scores and psychometric profiles** over the course of the programme. It also explores **perceived outcomes** and which factors staff, participants and stakeholders believe contribute to or hinder the programme from having a positive impact.
- Chapter 5 discusses the **conclusions** from the evaluation.

Each chapter is prefaced with a summary of key findings and concludes with suggestions for improvements to the programme. The concluding chapter revisits the three key research questions, as well as considering specifically how to strengthen future evaluation of MF:MC.

2. The operation of MF:MC

Key findings

General delivery

- Interviews with Treatment Managers and Practitioners indicate that, **overall, MF:MC appears to be delivered broadly in line with programme design** with respect to: length of group sessions; group size; staff roles; staff participation in mandatory MF:MC training; and Practitioner supervision and support.
- However**, most community sites were only running groups once a week**, rather than twice as recommended in the manual. This was primarily attributed to staff resourcing, although fitting around men's employment commitments was a secondary reason.
- There were **variations in the extent to which sites reported being able to take account of participant characteristics** (e.g. personality or offence type) in assigning men to groups. Where groups were skewed to men who offended against children, there was some concern about whether they were suitable for other types of offender.
- The **number of 2-1 delivery sessions in the community has exceeded expectations**, creating staff resourcing challenges, since teams had not planned for multiple 2-1 sessions being required alongside group delivery. Differing views were expressed on the relative effectiveness of 2-1 delivery within MF:MC.

The manuals

- The **MF:MC programme manual was viewed by staff as "*a little vague*"** and lacking in detailed content, with the Thinking Styles and Self-Management modules identified as particularly "*thin*". Staff reported spending considerable time identifying additional materials and content to support delivery, leading to inevitable variations between sites.
- There was a **lack of clarity about the extent of deviation from the manuals that is permissible** with respect to delivery of MF:MC sessions. In practice, sites identified various ways in which they adapted content and delivery, including: adapting for men with specific needs; adapting for different offences; changes to reduce perceived repetition; changes aimed at speeding progress to the optional modules; and adding content on topics not covered in the manuals.
- While one view (among both staff and participants) was that the **lack of direct focus on the offence** was a strength of MF:MC in comparison with previous programmes, others felt it created an *"elephant in the room*" and had adapted delivery so that the offence was discussed, at least briefly.

Transitions

- **Transitions from custody-based MF:MC groups to community groups** were facilitated by close discussions between teams, matching group entry to release date, ensuring social worker continuity, and transferring documentation promptly. Where these facilitators had not been in place transitions were perceived as more problematic.
- **Sites varied in whether they offered ongoing support** after the group stage of MF:MC. It was suggested that support around 'ending' the programme could be improved.

Resourcing

- **Staff resourcing was perceived to be extremely stretched in some sites** – MF:MC is funded through overall CJSW funding for each community site, rather than a ring fenced pot. There was a perception that there is considerable inconsistency in the level of funding available to MF:MC teams in different community sites.
- **Community sites do not have consistent access to a psychologist** to support delivery of the HSF module. There was a lack of clarity about how elements of this module are supposed to be delivered in the community.

Training and supervision

- While MF:MC training was viewed as providing an adequate initial base, **access to ongoing CPD relevant to MF:MC was reported to be extremely inconsistent**. Treatment Managers and Practitioners identified a number of topics on which they felt additional training was needed, either as part of or in addition to dedicated MF:MC training.
- In general, **MF:MC Practitioners appear to receive supervision and support in line with the manuals**, although the frequency with which these were provided was not always consistent. Treatment Managers did not appear to be receiving supervision or support consistently.

Data collection

- Interviews with Treatment Managers and Practitioners indicated **ongoing issues with the collection and collation of MF:MC monitoring data**, relating to: IT system design (which was perceived to limit its usefulness in supporting programme delivery); staff understanding of data requirements; timeliness of data collection and entry; and the perceived accuracy and usability of specific outcome measures (in particular, the psychometric measures).

2.1 Introduction

This chapter assesses how MF:MC is operating in practice, across the 15 sites (4 custody and 11 community) in which it is being delivered. It examines whether it is being delivered in accordance with its design and the reasons for any variations (either from the manuals or between sites). It also considers areas where changes may be required to ensure consistent and appropriate delivery. The findings draw primarily on interviews with Treatment Managers and the Practitioner workshop. However, where relevant, views from participants and wider stakeholders are also included. While MF:MC trainers were not interviewed for this evaluation (which focused primarily on delivery rather than training), written comments from the trainers' group on some aspects of the training package have also been incorporated to the relevant section.

2.2 Frequency and intensity of delivery

2.2.1 Programme design

The MF:MC Management Manual states that groups should be delivered three times a week in custody settings and twice a week in the community, with sessions lasting two hours plus a break. In custody, it is expected that a participant with a high number of treatment needs will spend a maximum of eight months on the programme, while in the community they will spend a maximum of twelve months in group. However, the manual

notes that individuals may need to re-enter the programme at a later date if they have outstanding treatment needs.

2.2.2 Delivery in the community

With two exceptions, community sites were only delivering group sessions once a week, with the result that men were reported to be spending considerably longer than twelve months on the programme in the community. While community Treatment Managers found it difficult to give an 'average' length on the programme, the estimated maximum length ranged from 18 months to 3 years.

Staff resource issues were the main reason Treatment Managers gave for only running groups once a week. In one case, the Treatment Manager cited plans to go back to running groups twice a week once more Practitioners had been fully trained. However, across other sites staff resources were seen as a long-term barrier to delivering at the frequency recommended in the manual. This was particularly (though not exclusively) the case where staff roles were split between MF:MC and other responsibilities (see discussion of staff roles, below). A secondary reason cited for only running community MF:MC groups once a week was that attending more frequently could be difficult for men to fit around employment.

Treatment Managers acknowledged that less frequent delivery slowed men's progress through MF:MC. However, views were divided on how much of a problem this created in practice. On the one hand, it was argued that provided men's Community Payback Orders (CPOs) were sufficiently long it did not cause any particular problems (some sites requested three year minimum orders to ensure time for MF:MC completion). On the other, Treatment Managers, Practitioners and a number of participants noted that when men only attend once a week there can be long gaps between sessions when they are 'in focus' (presenting their assignments), which can lead to feelings of impatience and loss of momentum.

2.2.3 Delivery in custody

Intensity of delivery in custody more closely reflected programme design – sessions were usually delivered three times a week, although recently one site had dropped to twice a week for at least one group because of staff resourcing issues. However, the length of time prisoners spent on MF:MC was nonetheless generally cited as longer than eight months to address all their identified needs. Treatment Managers reported it was common for participants in prison to roll off the programme for a period before re-entering, so they might spend 12 months on the programme altogether, but in two six month blocks (for example). Participants who had either repeated or re-entered the programme while in prison were generally positive about this – they reported that they found it more informative and felt they learned more the second time.

Overall, views (among both staff and participants and across custody and community settings) were divided on whether the programme was *"as long as it needs to be"* for individual men, or whether the programme was too long. While the length of time spent on MF:MC in part reflects frequency of delivery in different sites, Treatment Managers and staff also felt there was too much repetition in some elements of the programme, and that the number of sessions dedicated to the essential modules meant that there was sometimes insufficient time left on CPOs for participants to spend on the optional modules.

There was relatively little discussion about the length of group sessions: Treatment Managers reported that these last between two and three hours, in line with programme

design. Participants interviewed for this study indicated that, if anything, they would like sessions to be longer to allow more time to discuss problems.

2.3 Group size and composition

2.3.1 Programme design

The MF:MC management manual indicates that groups should consist of between 4 and 10 participants, with 8 recommended as optimal. It also states that "Attention is to be paid to the mix of individuals in the group and the group dynamic to ensure group cohesion can be maintained" (2014: 16). While a group-work format is the preferred model for delivery of MF:MC in the community, the manual also allows for delivery on a 1-1 or 2-1 basis.

2.3.2 Group size

Treatment Managers confirmed that MF:MC groups consist of 4 to 10 participants, with size varying depending on local demand and on the flow of men ready to roll on and off the programme at any given time. Interviewees highlighted the potential impact of the interaction between group size and frequency – in a custody site where frequency had recently fallen to twice a week at the same time as group size had increased to the maximum of 10, participants reported that the time between sessions when each man was 'in focus' had increased substantially.

2.3.3 Group mix

Treatment Managers expressed different views on how much scope they have to take account of factors like personality type or nature of offence in determining group mix. One view was that in practice, group mix is largely driven by either space, length of time left on order, or (for custodial settings) date of release. However, others reported that they do try to ensure a mix of men in terms of personality type or profile (for example, trying to avoid having more than one or two men with Personality Disorder or higher levels of psychopathy in the same group) and offence type (for example, trying to avoid having either only child offenders or only adult offenders in the same group).

The fact that it is not always possible to ensure a mix within groups in terms of offence type was reflected in comments from a Case Manager that the groups in their area were often mainly composed of child offenders. They felt this was problematic in terms of placing adult-only offenders on MF:MC, as they believed the discussion in groups was not always appropriate for that group. As a result, the Case Manager in question sometimes referred sexual offenders whose crimes were against adult women to the Caledonian Domestic Violence programme instead, which they felt was better able to address problematic attitudes about power and control of women.

2.3.4 Use of 2-1 sessions

All custody and most community settings were running 2-1 sessions at the same time as running MF:MC groups. In custodial settings, the use of 2-1 sessions appears to be routine for delivery of specific **sessions within the Healthy Sexual Functioning module** – something participants appreciated, as they indicated they would not wish to discuss these topics within group. Treatment Managers in prisons also reported using 2-1 sessions to follow-up with men who had difficulties understanding particular assignments, to build trust with clients who have problems engaging in groups, or as an alternative to group sessions for men with extreme sexual fixations.

In community sites, while rurality was one reason for delivering MF:MC on a 2-1 basis, Treatment Managers also cited a variety of other reasons for deeming group work either

inappropriate or insufficient for particular men. These related either to **men's specific needs** (anxiety issues, personality disorders, significant learning disabilities, and mental health problems were all mentioned), or to other **practical issues** (for example, issues fitting group times around employment). In some cases, 2-1 sessions appeared to be used in part to compensate for resourcing issues around group delivery – for example, using 2-1 sessions to enable men to finish MF:MC before the end of their order, or to allow them to start MF:MC before a place on a group becomes available.

The level of 2-1 delivery believed to be required to supplement group work in the community was viewed as a significant resourcing challenge: a number of Treatment Managers indicated that the level of 2-1 delivery had been higher than expected. There were also differing views about how effective 2-1 delivery is in the community. While it was suggested that 2-1 delivery can be more closely tailored to individual needs, there was concern that men miss out on the benefit of other perspectives from the group. A stakeholder interviewed for this evaluation expressed concern that 2-1 sessions were only playing *"lip service"* to the programme aims and that there needs to be greater consideration within MF:MC of how to meet the needs of men who are not able to attend group sessions.

2.4 Delivery of programme content

2.4.1 Programme design

MF:MC is intended to be "responsive, accessible and individualised in treatment approach" (Management Manual, 2014: 5). As discussed in Chapter 1, groups operate on a rolling basis, and the precise content that each individual will cover will vary depending on their treatment needs, as assessed during 'formulation'.

2.4.2 Delivering content in practice

The descriptions of MF:MC group sessions from Treatment Managers, Practitioners and participants all indicate that MF:MC sessions are planned and structured (in terms of which men are feeding back on their assignments and what materials facilitators might need to bring to support this discussion), but within the overall structure sessions are also flexible and responsive to the needs and issues that participants bring. Participants interviewed for this evaluation generally reported that they found MF:MC sessions engaging - they praised facilitators' skill in creating an atmosphere where they could be open, the range of activities they brought to sessions, and the fact they felt facilitators cared about participants:

> *There is no doubt obviously they're in charge, but it's a relaxed atmosphere, which helps I suppose, when people need to talk (about) what they need to talk about.*
>
> (MF:MC participant 11)
>
> *Obviously they always try to mix it up and do different things so at least, aye, it might not work for one person, but at least they're trying to please everybody.*
>
> (MF:MC Participant 2)
>
> *I would very clearly state it is all professional, there is no crossing line, never has been any kind of crossing line, but at the same time I'm deeply*

appreciative that they do genuinely seem to have a bit of care for me. I'm not just like a subject, I'm not just like a number.

(MF:MC Participant 7)

Because a degree of flexibility in delivery style and content is built into MF:MC, it is difficult to assess the extent to which delivery in practice is deviating from the design. Among Treatment Managers the programme's flexibility was seen as a positive, but there was also some concern about how much adaptation from the manual in terms of delivery is actually acceptable:

It does sometimes worry me slightly … how much you are supposed to stick very strictly to the kind of programme manual, or how much licence we have to kind of adapt and be creative, as long as we're sticking to the kind of main theories and concepts and all the rest of it.

(Treatment Manager 9)

Treatment Managers and Practitioners identified a number of ways in which they felt they were adapting the programme content and delivery from what is explicitly set-out in the manual:

- **Adapting content for men with limited cognitive ability or other specific needs** – Treatment Managers described their teams adapting some of the language of assignments to make them less complex, or introducing visual methods for those with poor writing skills or for younger men. One community site has gone further and is running a separate dedicated group for men with low cognitive function. They felt that working with this group on a rolling basis was too complex and confusing and was difficult to manage in terms of group dynamics. Their dedicated group for men with low cognitive function involves shorter sessions (because of perceived issues around their concentration levels) and is not rolling – instead of having one or two men in focus each session, they aim to pull out common goals across the group and work through these in order. The Treatment Manager for this area acknowledged that this was a very different approach to that set out in the manual. It was suggested that a similar approach might also be appropriate within SPS. One view was that this would not only improve the experience of men with lower cognitive function, but also the learning of those with higher levels of cognitive ability, who can become frustrated at the pace of more inclusive groups.
- **Adapting for different offences** – Treatment Managers more commonly discussed adapting the programme for different individual needs rather than for particular offences – they indicated that two men could have committed very different offences but have very similar treatment needs. However, as discussed in the following chapter, there was some debate about the suitability of MF:MC for internet-only offenders (both in terms of whether they posed a sufficiently high risk to be on the programme and whether the content reflected their specific treatment needs). As a result, one site had developed a separate, non-accredited, programme for internet offenders which they ran alongside MF:MC. This used some material from MF:MC and some from the earlier Good Lives programme, but focused in more detail on issues the Treatment Manager felt were more central to that group of offenders (for example, issues around pornography).

- **Changes to reduce perceived repetition** – for example, combining the 'People in my life' and 'Relationships' assignment into one, as these were seen as very similar in content.
- **Changes aimed at moving participants on to optional modules more quickly** – as noted above, Treatment Managers in several sites discussed the fact that they felt participants often spent too long on the 'essential' modules and were not always left with sufficient time to spend on optional modules, which were viewed as central to addressing the treatment needs of some participants. Several sites had adapted their approach to try and address this issue:
    - A custody site was piloting a new approach to 'Discovering Needs' whereby rather than covering this module in group sessions, participants work through their individual needs 2-1 or 1-1, and then have a shorter number of group sessions aimed at introducing and gauging their level of knowledge of key MF:MC concepts. The Treatment Manager hoped that this would reduce the length of time spent formulating needs and allow prisoners to progress through the programme more quickly.
    - A community site had combined some initial assignments, again with the aim of shortening the Discovering Needs module in order to progress to the optional modules more quickly
    - Another community site reported bringing in elements from the optional modules while men are working on the essential modules if they identified something they felt a man needed to work on. They felt this approach was more responsive to what men were bringing to the group at the time.
- **Adding content that is not covered in the MF:MC manuals** - in addition to introducing supplementary resources to support topics covered in the manuals (see discussion below, section 2.7), several sites also reported introducing additional topics they thought were not included in the manuals, including: internet safety, social media and on-line grooming, body language, and assertive vs. aggressive behaviour.

2.4.3 Discussing the offence within MF:MC

There was a specific debate apparent across interviews with Treatment Managers and Practitioners around the lack of a direct focus on discussing the offence itself within the MF:MC manual. Some Treatment Managers and Practitioners felt that avoiding discussing the offence altogether created "*an elephant in the room*" and created a number of problems in delivery, including:

- Making it **more difficult to challenge participants** when their accounts conflict with what is known about their offence
- **Reducing the scope for pointing out the links** between risk factors and offending behaviours
- **Creating an inadvertent hierarchy of offending**, since internet offenders are, according to some Treatment Managers, more likely to disclose their offence unprompted in the context of minimising its perceived significance (in comparison with other sex offences).

These sites reported adopting different approaches to this issue in practice. Some suggested men mention their offence briefly in one of their early group sessions. Others

introduced content from the earlier Community Sex Offender Group Programme (CSOGP) around discussing the offence (for example, material around the 'Cycle of Offending').

However, other Treatment Managers felt strongly that the fact that MF:MC does not focus on the offence directly is a **positive feature** of the programme and avoided any discussion of this within groups. They believed that focusing on the offence was ineffective and likely to lead to disengagement.[4]

Participants' views on discussing the offence (or not) within MF:MC mirrored this divide. Some viewed the fact that MF:MC is not offence-focused as a positive compared with other programmes (including previous sex offender treatment programmes, where participants had experience of these), and cited this as a factor that helped convince them to take part:

> *I wasn't up for it at first. In my mind I just wouldn't do it, I wouldn't sit in a group and tell about my offence in graphic detail, I wasn't willing to do that. (…) the old Core Stop, it was horrible (…) But this is totally different, it's the complete opposite.*
>
> (MF:MC Participant 4)

However, others echoed the view of some staff that avoiding discussing their offence turned it into "*the elephant in the room*" and could make discussion evasive. One participant who had not had the opportunity to discuss his offence at all within MF:MC expressed some frustration with this:

> *In fact, I actually had more of a mind-set, we'll discuss more about the actual crime, when I kind of later realised that isn't really the big emphasis (…) I've been maybe the odd time, eager to talk about the actual crime, mainly because there is a lot of things I want to know, a lot of the answers (…) But, no, so sometimes I may have to be reined in, I suppose, by just understanding, that we have got to go through a bit of a process first.*
>
> (MF:MC Participant 5)

2.5 Managing transitions

2.5.1 Between custody and community settings

As MF:MC is delivered to men in both custody and community settings, men may transition between the two: from custody to community if they are released before finishing (or before starting) the programme, and from community to custody if they are recalled or reconvicted while on license. According to Treatment Managers' accounts, the frequency

[4] While research indicates that acknowledging the offence is not a pre-requisite for successful treatment of sex offenders (e.g. Marshall et al, 2001), we were unable to find definitive evidence on the specific question of whether or not the offence should be discussed or avoided during treatment. Private communication with the research team from a Canadian academic expert on the treatment of sex offenders outlined similar arguments to those discussed above as to why it might be viewed as helpful to discuss the offence - particularly in terms of helping offenders to understand the cognitive distortions and other risk factors that led up to the crime. On the other hand, he highlighted the need to mitigate against the possibility of discussion of the offence leading to arousal, bragging or bravado, as well as noting links to the wider debate about the potential for mixing risk groups to lead to unintended negative consequences (that exposure to the experiences and language of more anti-social peers can undermine the scope for programmes to have a positive impact on lower-risk individuals) (see for example Lloyd et al, 2013).

of these transitions varies considerably across sites – some Treatment Managers could not comment on this as they had not experienced many such transitions. Where transitions between sites were discussed, the focus was generally on those transitioning from prison to community. Views on how well these transitions were managed and how effectively information was shared between sites varied. Where Treatment Managers felt it worked well, key factors included:

- **Close discussions/meetings with prison MF:MC teams**, including undertaking joint formulation with them
- **Tying entry to community MF:MC groups with release dates**
- **Continuity provided by the prisoner's allocated social worker**, who is involved while they are in custody through the Integrated Case Management process
- **Prison teams transferring documentation promptly** and ease of transferring data from one site to another within the MF:MC IT system.

However, more critical views were also expressed, including:

- **A lack of face-to-face contact** between community and custody MF:MC teams in some areas
- **Long gaps** between release from prison and participants being allocated a place in a community MF:MC group (in one case, a participant reportedly re-offended in the 8-month interim period)
- **Difficulties fulfilling participants' treatment needs on release to the community** because of differing resources – in particular a lack of psychology input to deliver elements of the Healthy Sexual Functioning module (discussed further below).

2.5.2 Ending MF:MC

Another key transition comes at the end of MF:MC, when participants have finished their assignments and group work. The manual states that the post-treatment process should assess how successful MF:MC was in meeting their support needs. There is no general requirement for ongoing support by the MF:MC team (unless a participant is re-entering the programme), although the Manuals state that participants may be offered 'optional maintenance sessions'.

In practice, community sites varied between those who did not offer any particular follow-up with men after the post-programme report, viewing this as the Case Managers' role at that point, and those who offered some kind of follow-up from the MF:MC team themselves, including:

- **Allowing/encouraging men to come back to groups** on an occasional or regular basis
- **Running specific 'drop-in' sessions** for men who have left MF:MC where they can speak to staff and get support with things like training and jobs
- **Offering one-to-one support** over the phone or in person.

It was suggested by MF:MC facilitators that ending the programme can be difficult for participants, as the groups provide an important social outlet for some men. This view was echoed by some of the participants we interviewed – they described ending MF:MC as an *"anti-climax"*, indicating it had ended quite abruptly and there had been limited support for putting the skills they had learned into practice. One view among facilitators was that there

is not much formal scope within the programme to look at what ending MF:MC means for participants, and that further consideration around supporting this transition is needed – for example, it was suggested that there may be a need for a community development worker role, with a remit explicitly focused on supporting men to put the skills learned on MF:MC into practice.

2.6 Programme resources

2.6.1 The manuals

As discussed in Chapter 1, MF:MC is underpinned by a series of manuals that set out the programme theory, structure, content, management requirements, and framework for collecting data for evaluation. Treatment Manager and Practitioner views of the manuals tended to focus on the Programme Manual, which sets out MF:MC's content. There was a general perception that this was *"a little vague"* and that it did not include sufficient content to support delivery of all sessions. While one view was that this was to an extent an inevitable consequence of MF:MC being flexible and responsive to individual needs, staff reported spending a lot of time identifying additional material (worksheets, videos, activities) to enable them to deliver sessions in an informed and engaging way. This led to inevitable variation in precise activities and approaches between sites, as well as duplication of staff time and effort to identify suitable resources.

Specific areas where the manuals were viewed as particularly *"light on content"* included:

- **Thinking Styles** – both Treatment Managers and Practitioners identified this as an area that was somewhat "*shallow*" in the manual. Psychologists in custody settings noted that they were drawing on wider psychological training to deliver this (although it was not an area all psychologists were trained in or comfortable with), but thought that this might be more difficult for social workers. At the same time, a perceived lack of clarity in the manuals around the depth of 'Schema' therapy work anticipated within MF:MC was seen as resulting in wide variations between sites in how the Thinking Styles modules are approached.
- **Self-management** – it was suggested that the assignments in this module lacked detail and depth, and that the content only *"skims the surface*" of what Treatment Managers and practitioners felt they needed to cover with participants, particularly for young offenders and men with emotional difficulties and/or Personality Disorder.

Treatment Managers and Practitioners also questioned whether the manual needed to include a wider range of techniques – including more behavioural techniques – to enable them to address participants' diverse presenting needs. Some of the materials that were included in the manual were seen as somewhat simplistic – for example, a Case Manager said participants told her they found the use of pictures on assignments patronising. However, at the same time, others felt more needed to be done to make assignments and materials accessible – as noted above, in some cases staff felt they had to adjust the language used for men with lower cognitive functioning.

There was also a view – again, reflecting adaptations to the programme discussed above – that there was too much repetition between particular modules and assignments as set out in the manual. In addition to those noted above, there was perceived to be unnecessary overlap between the 'Moving to the Future' and 'Managing the Future' modules, and between the Case Management pre-group sessions and the 'Entry module'. The latter point in particular was reflected in comments from participants, who felt that the programme became particularly repetitive when new participants rolled on to group and key concepts had to be reiterated repeatedly. The pre-group sessions in the manual also

caused some issues – a Case Manager indicated that they skipped some of the content as they found it difficult to follow and were not clear on the purpose.

2.6.2 Staff resources

As discussed in Chapter 1, the qualifications of staff delivering MF:MC are intentionally different in custody and community settings. In prisons, the programme is delivered by psychologists and prison officers; in the community, it is delivered by social workers. In addition, MF:MC teams in the community work closely with Case Managers.[5] Case Managers deliver MF:MC pre-programme sessions in the community, to prepare men for group work. There is no equivalent role on MF:MC in prison. In both custody and community settings, MF:MC teams comprise Treatment Managers, Practitioners and Programme Managers (who may, in the community, also be Treatment Managers). The Management Manual states that, when the programme is being delivered without a Level 1 Practitioner, it is also expected that Treatment Managers should actively participate in delivery at least 1 in every 6 sessions, alongside their operational management responsibilities.

All MF:MC teams had staff in the required roles discussed above. However, the structure of MF:MC teams across community sites in particular varied in terms of:

- Whether MF:MC practitioners were **exclusively delivering group work**, or whether they **also had Case Management responsibilities**
- **Whether teams worked exclusively with sex offenders**, or whether they also carried out other Criminal Justice work (for example, delivering domestic violence interventions)
- **What proportion of staff time was dedicated to MF:MC** versus other roles (Treatment Managers estimated that this ranged from around 50% to 100%)
- **Whether or not the Treatment Manager was regularly involved in facilitating groups** – in some cases, they stated they only did so to provide cover, while in others they were delivering far more regularly than 1 in every 6 sessions, primarily as a result of staff shortages.

Delivery structures are not specified by the manual (provided the required roles are provided), and there was no consensus as to which delivery structure works best - one view was that in areas with lower demand for MF:MC staff needed to be able to deliver more than one role to allow a big enough team for effective delivery, while another site felt they would be unable to meet demand without full-time MF:MC practitioners. However, the frequency with which Treatment Managers are involved in delivery in some areas may have implications for their capacity to fulfil their other responsibilities.

Across both community and custody sites, Treatment Managers' views of the adequacy of their current staff resources were split between those who felt they had enough to deliver at their current level and frequency (i.e. once rather than twice a week in the community), but not above, and those who felt they were really stretched to deliver even at their current level of intensity. There was a perception in both Community and Custody sites that teams were operating with very limited resilience to cover staff absence or leave, and that it was very difficult to find time for discussing complex cases or for staff development. The length of time it could take to recruit, develop and train a new staff member to be able to deliver MF:MC (which varies depending on experience and competency but could be up to two

[5] Criminal Justice Social Work staff allocated to supervise sex offenders while they are on license or on CPO/Probation Orders.

years) also meant that dealing with turnover could be extremely challenging. MF:MC in the community is funded by local authorities – there is no specific ring-fenced funding for the scheme. Changes to local funding as a result of the dissolution of Criminal Justice Areas were reported to have had a negative impact on MF:MC resourcing in particular Community sites (in one area, the budget had reportedly been halved as a result), while in others uncertainty about future funding was causing concern. There was a perception that there is not enough consistency in MF:MC teams' funding across Scotland:

> *For staffing, there is no reflection that sex offender numbers are going up. I know we are all working in a time of cuts and austerity, but if [the Scottish Government] want us to provide a programme, with a repeated frequency throughout the week, you can't just do that with standstill staffing.*
>
> (Treatment Manager 8)

In Custodial sites, Treatment Managers commented on the challenges for staff of managing delivery of MF:MC alongside their other workload, with impacts both for MF:MC and for their other roles. One Treatment Manager, who was meant to have a dual role, reported that she was spending 80% of her time on MF:MC due to staffing shortages. There was a strong perception that prison-based teams could do more to enhance delivery of MF:MC – for example, spending more time discussing complex cases as a team – if they had more time, but as things stood they were *"just getting by"*.

2.6.3 External psychological support for delivery in the community

In addition to the core staff team required to deliver MF:MC, the Management Manual also states that "The delivery of HSF (Healthy Sexual Functioning module) requires to be done under psychological supervision … in the community, this is provided by the central psychological support role" (2014: 30). Interviews with community Treatment Managers and Practitioners indicate that community sites do not have consistent access to someone in this role. Several sites reported that they did not have any external psychological support, or had been without it for extended periods (it was noted that the Risk Management Authority had been contracted to provide someone in this role to help support community sites, but funding for this post came to an end in 2016). Where community teams did have access to a psychologist, this tended to be for a fixed number of days per year to provide training, support and advice to the MF:MC team. This was confirmed by an interview with a psychologist who supported MF:MC teams – their role involved providing individual support and counselling to MF:MC staff, updating staff on developments in particular topics, training and coaching staff around particular techniques, and discussing issues arising with particular men.

Some Community Treatment Managers were content with this arrangement, in part because they believed there was limited need or demand for the particular sessions of HSF (involving behavioural modification techniques) that might require more direct psychological input. However, others felt it was unclear how HSF was meant to be delivered in the community and wanted clearer guidance on this:

> *We could use that psychologist for oversight if we needed to do any of the behavioural modification, but there is still no clear answer, as far as I'm aware, from the Scottish Government, about how that kind of behavioural modification work would be done over time … in community more generally.*
>
> (Treatment Manager 9)

2.6.4 Training

All MF:MC Practitioners must attend an initial core week of MF:MC training, which is currently organised nationally and runs twice a year. This is supplemented by a second week of training covering Mindfulness, Healthy Sexual Function and Thinking Styles, and a third week covering personality disorder, MFMC with Learning Disability, and Psychometrics. In general, the current training was viewed as providing a satisfactory initial base for staff (in combination with the experience and training provided within sites). The structure and delivery of training was changed considerably following feedback from the initial Treatment Managers' training in November 2013 and initial facilitators training in January 2014. Reflecting this, there was some concern about whether practitioners and Treatment Managers trained very early on in the programme had been trained to the same level as those trained more recently.There was a perception among Treatment Managers that some additional training focused specifically on how to treatment manage would also be useful in terms of equipping them to understand their role and responsibilities.

A 2016 RMA evaluation of MF:MC training provides a detailed assessment of staff views on the training provided. Whilst the evaluation made recommendations for improvement, for example around the language used and the need for more practical examples, the report concluded that overall most staff had favourable opinions of the MF:MC training (RMA, 2016a).

However, current access to *additional* Continuing Professional Development (CPD) relevant to MF:MC – which staff agreed was essential to effective delivery – varied widely between sites. Funding for CPD appeared to be a particular challenge for those working in custody settings:

> *I think that comes back to the lack of funding, because there is courses that we all want to go on that would help us get that, but we don't get that funded. Like things like conferences, like sex offender conferences, just basic, we don't get those funded.*
>
> (Treatment Manager 10)

Specific modules and topics staff felt they needed more training on, either within or in addition to MF:MC-specific training, included:

- **Thinking Styles and Schema therapy**
- **Healthy Sexual Functioning** - Practitioners noted that the MF:MC training does not cover the specific component of behaviour modification in sufficient depth (linking to the point above about a lack of clarity and support from a designated psychologist as to when and how these sessions should be delivered in the community). They felt it would also be helpful to cover a wider range of techniques for approaching this topic
- **Trauma** – although the manual suggests that MF:MC should not focus on trauma (and that men should be referred to specialist services to address this), there was nonetheless a perception among Practitioners that they needed more skill in this area to work with men who had experienced childhood trauma. It is worth noting in this context that Community Justice Scotland are developing a specialised course on individuals who have experienced childhood trauma, which may help to address this training need among community practitioners.
- **Differences between CSOGP and MF:MC** (particularly for those trained in delivering CSOGP)

- **More on the theory behind the programme** (identified as a need for prison officers particularly, who felt they would benefit from this in advance of the main MF:MC training)
- **Group work skills** for those with less initial experience of this[6]
- **Formulation of treatment needs,** which Practitioners felt was not well integrated in the training package.

A number of these issues have also been identified by the MF:MC Trainer's Group, who have identified the need to redesign elements of the training. It was suggested that gaps in the Thinking Styles module restricts training delivery in this area – an issue the Trainer's Group has highlighted to SAPOR. Similarly, trainers have also identified a need to examine the design of training around behaviour modification and formulation of treatment needs, which trainers suggested was not well integrated into the original training package, but did not undergo major changes in advance of this evaluation.

2.6.5 Supervision and support

MF:MC Group Work Practitioner competencies should be reviewed regularly by Treatment Managers watching sessions (live or recorded), every three months for Level 2 Practitioners, and every 6 months for those at Level 1. Practitioners should be allowed to debrief within 5-10 minutes of delivering sessions and should receive mandatory counselling every three months.

Treatment Managers indicated that they did aim to stick to this supervision schedule, although in some cases they acknowledged that this could slip due to time pressures. One site had reduced the frequency of competency reviews from 3 to 6 months, as they felt that every 3 months was excessive when some of their staff were only delivering one group a month. A number of Treatment Managers across community and custody sites noted, however, that they were not themselves receiving any formal supervision or competency assessments as part of MF:MC.

Similarly, Treatment Managers and Practitioners confirmed that counselling was made available, but not always as frequently as every 3 months. In terms of support within teams for staff, it was suggested that in prisons it could be harder for staff to bring their own personal feelings and worries to supervision sessions – there was a perceived expectation of resilience among staff working in prisons. This experience did not appear to be shared by Practitioners working in Community settings, who reported excellent support from peers and managers.

2.6.6 Other resources

The main additional resourcing issue staff raised was the need to identify additional materials to support delivery (discussed above, 2.6.1). This was a particular challenge for custody sites – Practitioners working in prisons reported that their access to online resources was constrained by SPS restrictions on what staff can access on the internet, while they are unable to use basic materials like scissors, and did not have access to things like DVDs, materials to use in mindfulness meditations etc.

[6] Although the MF:MC manual states that staff should have completed their own organisation's Group Work skills package prior to attending MF:MC training, there was nonetheless a perception that staff who were less familiar with delivering group-based programmes would benefit from additional training on this.

2.7 Data collection by MF:MC sites

The monitoring data system for MF:MC has been developed to ensure consistent data collection across MF:MC sites for evaluation purposes. MF:MC teams are required to enter a range of data for each participant, including:

- Pre and post-programme measures of risk factors and psychological traits
- Progress on each MF:MC module
- Reasons for removal from MF:MC (where applicable).

In practice, the usability of monitoring data for both evaluation and programme delivery purposes depends on a combination of system design, staff understanding of data requirements, timeliness of completion, and the perceived accuracy and usefulness of the data collected to populate it. Interviews with Treatment Managers and Practitioners indicated that there are ongoing issues relating to each of these factors:

- **System design** – There was a perception among staff that the IT system had not been set up in a way that was useful in supporting delivery as well as evaluation – for example, by enabling teams to predict completion rates, see what modules clients should be entering next, etc. Staff also disliked the inability to store data from more than one iteration of MF:MC for each participant (if participants repeat modules or the entire programme, the data entered is for their most recent 'run'), which they viewed as losing potentially useful information. Functions intended to ensure data is not omitted were, in practice, viewed as "*clunky*" and as risking inaccuracies in the data – for example, since it is not possible to move forward in the system before entering Risk Matrix 2000 (RM2K) score7, in some cases MF:MC staff were entering a 'placeholder' score to enable them to continue.
- **Staff understanding of data requirements** – there was an ongoing lack of clarity among Treatment Managers about whether teams were meant to record every session attended by a participant, or only those where they were 'in focus' (i.e. feeding back their assignment), resulting in inconsistencies in data between sites.
- **Timeliness of completion** – while Treatment Managers stated that they attempted to ensure the monitoring data was up to date, they acknowledged that when staff time was pressured, this was one of the first things that slipped. In part, this reflected a perception among MF:MC teams that the data was not helpful to actually running the programme; as such it was not accorded priority.
- **Accuracy and usability of data collected** – MF:MC staff expressed strong concerns about the validity and usability of data collected via the 8 psychometric scales included in the programme. Concerns about validity are discussed in Chapter 4, as these are relevant to their use in assessing programme outcomes. In terms of usability, at present, none of the sites reported using data from the psychometric tests to inform delivery in any way. Treatment Managers reported that teams are not trained on how to interpret them or use them to support formulation or treatment. It was suggested that some of the tests – for example, the impulsivity and social romantic loneliness scales – might potentially be useful in informing treatment. However, the overwhelming consensus across Treatment Managers and

[7] RM2K is a measure of 'static' risk factors for re-offending. These are factors that are relatively immune to change but which analysis of group data suggests are often associated with recidivism.

Practitioners was that without further guidance and training the psychometrics were simply an *"admin exercise"* and of no use to delivery staff. Treatment Managers wanted guidance from SAPOR on how to use them.

> *At the moment, I think they are meaningless. There isn't a comparative dataset to rate them against. We're not adequately psychometrically trained. So we are basically asking people to tick some boxes and they are being put in a folder and remaining there. So I do question the value of them. Only when staff are adequately trained to interpret them could we make use of them.*
>
> (Treatment Manager 3)

2.8 Suggestions for improvement

The findings above, in combination with suggestions made directly by interviewees, indicate a number of areas where changes may be needed to strengthen the operation of MF:MC, including a potential need to:

- **Review funding structures and levels for staff teams**. If resourcing issues limit the ability to deliver a programme with fidelity to its design, programme outcomes may also be put at risk. In light of the general concerns discussed above about lack of capacity to cover absence or staff development, and the fact that most Community Teams are currently unable to deliver MF:MC at the intensity recommended in the manual, there appears to be a need to review funding.
- **Review the extent of 2-1 delivery within MF:MC**, and the implications in terms of resourcing.
- **Clarify the intended role of psychological support in the community**, and ensure that all sites have access to this.
- **Increase MF:MC training frequency and strengthen opportunities for CPD relevant to MF:MC**, ensuring that resources for CPD are consistently available across all sites.
- **Review the training, development and quality assurance needs of Treatment Managers**, particularly those who are not directly involved in the delivery of the MFMC programme.
- **Create more opportunities for staff to share learning and discuss practice**, for example by holding regular national staff workshops (suggested at the Practitioner workshop), or creating opportunities for Practitioners from custody and community settings to shadow each other. Case Managers also suggested they wanted to shadow some group sessions, to find out more about how MF:MC works.
- **Create a central 'Knowledge Hub' for MF:MC resources**, which can be regularly updated with new material to support delivery (including both material for direct use in MF:MC sessions, and material to support staff learning on particular topics).
- **Review the content of manuals** (particularly the Programme Manual) to:
    - **Consider what additional materials and activities may be needed** (either within the manuals themselves, or as part of a central MF:MC 'Knowledge Hub') to support consistent and effective delivery of the current content (drawing on comments from staff about areas where the manuals are seen as "*thin*") and make materials available to all sites.

- **Identify any additional topics that should be covered** – suggestions from staff included social media and online grooming, stress as an emotion, and fantasy and its link to internet offending
- **Identify additional techniques that may be required to support delivery** (and provide further clarification and guidance around the use of existing techniques, including Schema Therapy)
- **Identify and reduce any unnecessary overlap** between assignments and modules. A related suggestion was that the Manual should include more guidance on different 'individual pathways' through MF:MC – including whether some participants who display a higher level of understanding of key concepts and the factors contributing to their offence could progress to the 'optional' modules and work on specific skills more quickly.
- **Clarify guidance on discussing the offence as part of the programme**. This could include suggesting potential ways of talking about the offence without making this a barrier to participation, and/or providing guidance on how to handle the difficulties that participants and Practitioners feel arise when the offence is 'off the table'
- **Review the language used in assignments** and the way they are presented to ensure they are accessible for men with different cognitive abilities
- **Consider whether additional guidance is needed on delivering MF:MC to clients with specific needs** – specific suggestions from staff included young offenders and clients who speak English as a second language.
- **Consider whether or not Case Manager materials are sufficiently clear** on the purpose of each session/activity they are asked to complete with participants.

- **Consider how updates to manuals are communicated** – practitioners indicated they would prefer changes to be communicated face-to-face, for example via an annual MF:MC update or workshop, rather than by email.
- **Provide greater clarification on the degree of flexibility and adaptation of the manuals that is permissible** within MF:MC without compromising programme integrity.
- **Review the use of and guidance around psychometrics**. Issues around the outcome measures included in the programme in general, and the perceived validity of the psychometric scales in particular, are discussed in Chapter 4, which recommends a wider systematic review of outcome measures for MF:MC. However, *if,* following further review, any of these scales are retained as a core part of MF:MC, further training and guidance is required to enable teams to use them to inform treatment.
- **Review both resourcing for, and guidance on, 'ending' the programme and post-programme 'maintenance'** to ensure a consistent approach to offering post-programme support and helping men to implement the skills they learn while on MF:MC.
- **Review whether the IT system can be improved** to ensure that it is both better able to deliver data that is both useful for evaluation and helps support delivery. Any changes should, ideally involve user testing with staff from different sites. Further

training, support and guidance may also be required to address ongoing differences in understanding of data requirements.

3. Participation in MF:MC

Key findings

Referral and assessment process

- Interviews with MF:MC staff indicate that **the referral and assessment process appears largely to be followed as outlined in the manuals**. However, there is some variation between sites with respect to: the precise stage at which the pre-programme SA07 is conducted; who conducts the pre-programme SA07; the process for determining suitability (as distinct from eligibility); and the assessment of deniers (an issue on which it was suggested further guidance or training might be required).
- **For the most part, MF:MC is successfully targeting men rated as 'high' or 'moderate' risk** – just 2% of participants were rated 'low risk' based on their pre-programme Stable 2007 score.
- However, some concerns were raised about whether the current process always identifies those most suitable for the programme, including:
    - whether SA07 is always completed accurately and based on sufficient information to make a realistic assessment of risk
    - whether SA07 omits a number of key risk factors, specifically around thinking styles and attitudinal risk factors, and
    - the perceived inadequacy of the current process for identifying whether or not internet offenders are suitable for MF:MC.

Participation, attrition and completion

- The **proportion of men who refuse to participate in MF:MC was generally believed by staff to be low**, particularly in the community where it is usually a condition of men's CPO. Participants cited concern about confidentiality as one reason for refusing to participate in MF:MC when in custody.
- Limitations in the monitoring data for MF:MC mean it **can only provide an imperfect estimate of the number and profile of men starting, completing and leaving MF:MC**. However, taking these limitations into account an estimated:
    - 911 men had started MF:MC, most (81%) in a community site
    - between 230 and 266 were recorded as having fully completed the programme, and
    - 97 men were recorded as having left the programme before completing all their prescribed modules.
- Where a reason for leaving early was recorded, the most common were: insufficient time on the man's order or time left in custody to complete; being recalled or having breached their order; and personal reasons such as poor health or change in employment circumstances.

Attendance and engagement

- **Attendance at MF:MC sessions was reported (by staff) to be very high**. In terms of active engagement, participants' comments suggested that starting group work and new members 'rolling on' to the programme are both points where, for different

reasons, engagement may sometimes be lower. However, overall, participants and staff both felt that **engagement was primarily influenced by an individual's own motivation**, rather than programme stage, offence type, age or cognitive ability.

3.1 Introduction

This chapter discusses the level and nature of participation in MF:MC, including:

- the referral and assessment process and the extent to which this is believed to identify the men who are both eligible and suitable for the programme
- the level of participation, completion and attrition on MF:MC to date, and the reasons for non-completion
- perceived engagement with MF:MC.

The information in this section is based on a combination of feedback from Treatment Managers, Practitioners, participants and stakeholders, and analysis of the monitoring data recorded by each delivery site.

3.2 Referral and assessment

3.2.1 Outline of the intended process

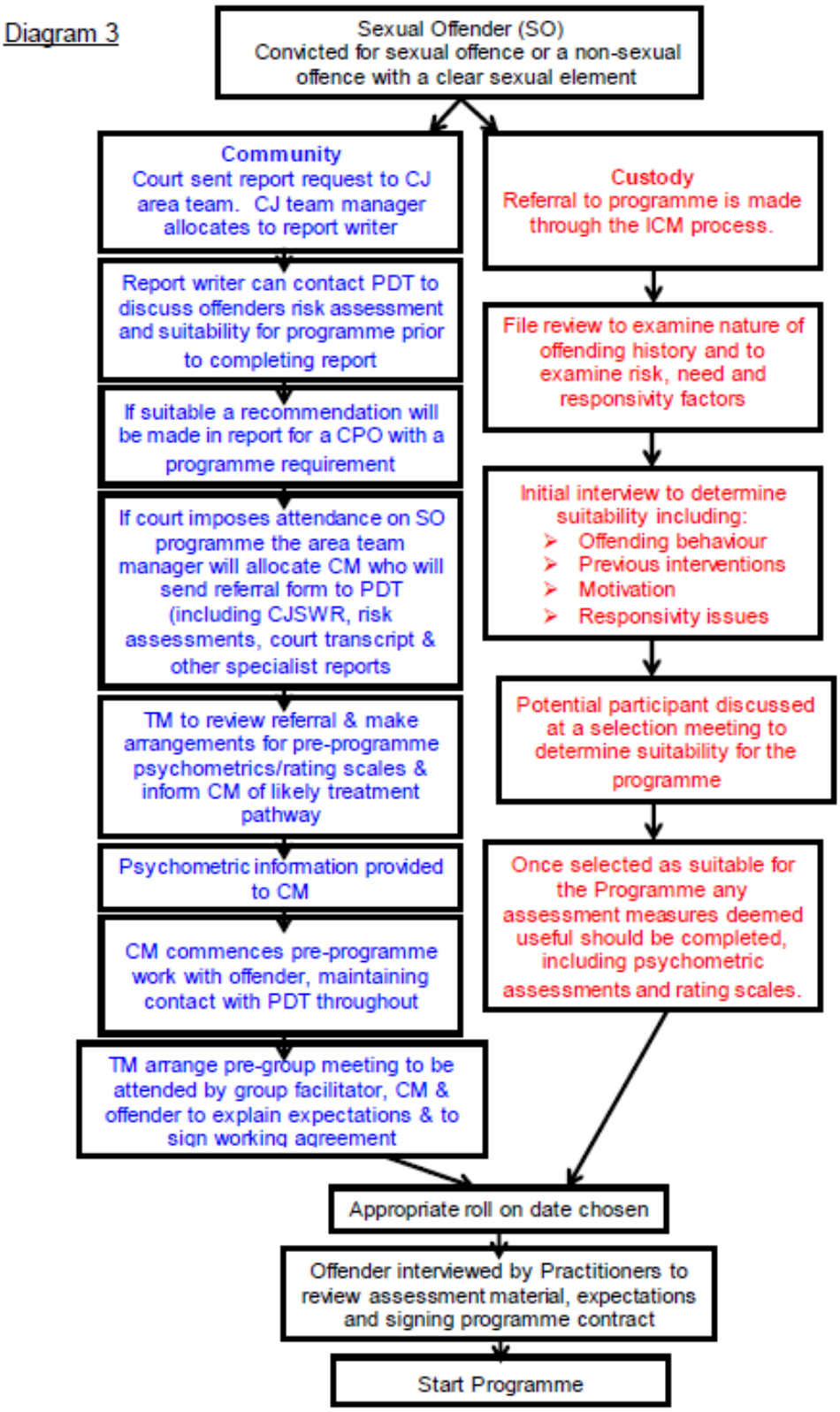
The process of referral to and assessment for MF:MC outlined in the manuals differs between prison sites and community sites. The different pathways are summarised in Figure 3.1, below. In prison, referral to the programme is linked to the Integrated Case Management process. Men are assessed for suitability for a range of programmes available through SPS through the generic programmes assessment process, which involves:

- a file review to examine offending history, risk, need and responsivity factors
- an interview (covering their offending behaviour, previous interventions, motivation and responsivity issues),
- discussion at the Programmes Case Management Board to determine suitability for the programme (including discussion of risk level, denial, time remaining in custody, motivation level, and what needs to be put in place to ensure the programme is responsive to their needs).

Once identified as suitable for MF:MC, an appointment is arranged for the man to be interviewed by MF:MC practitioners, where they carry out a more detailed assessment, using the Stable and Acute 2007 tool (SA07, see below), upon which eligibility for entry onto the programme is predicated. In custody, a completed SA07 should be available for the Programmes Case Management Board – if this is not available, an assessment would be requested from the prison-based social work team.

In the community, a potential MF:MC participant is identified following a conviction in court for a sexual offence. A member of the Criminal Justice Area Team will complete a Criminal Justice Report on the man in question, which may recommend that MF:MC is imposed. The report writer may contact the MF:MC team to discuss the man's risk assessment and suitability for the programme prior to completing the report. If the court has already imposed attendance on a sex offender treatment programme prior to assessing eligibility, the Area Team manager will allocate a Case Manager for the man, who will carry out the relevant assessments. In either case, the referral will be reviewed by the MF:MC Treatment Manager to ensure it is appropriate.

Figure 3.1 Standard referral and assessment process (taken from the MF:MC Assessment and Evaluation manual)



The assessment process for internet offenders as outlined in the manual is different to that for contact offenders. The Assessment and Evaluation manual provides a 'decision tree' for determining suitability of internet offenders for MF:MC, taking into consideration both their SA07 and the Risk Matrix 2000 (RM2K) scores, plus consideration of aggravating factors (including criminal history, access to children, and types of images viewed). Following this process may result in a recommendation for MF:MC, or for treatment through case management alone. The decision tree is shown in Annex B, Figure B.1.

3.2.2 Extent to which the assessment process follows the manuals

The referral and assessment process appears largely to be followed as outlined in the manuals. However, there is some variation between sites with respect to: the precise stage at which the pre-programme SA07 is conducted; who conducts the pre-programme SA07; the process for determining suitability; and the assessment of deniers.

First, the **stage at which the pre-programme SA07 assessment is carried out varies between the community sites**. Some carry it out at the court report stage, while other sites appear to wait until the man is further into his treatment order (in some cases having completed some of the pre-group work), on the basis that it is more accurate and more useful in formulating treatment needs at that stage:

> *We don't do the SA07 at the court report stage…. Here it isn't done until the man is three months into the order. At that point, there is more information to populate the SA07 and at that point you can look better at whether the man is suitable or not.*
>
> (Treatment Manager 14)

Second, **who carries out the pre-programme SA07 appears to vary between community sites** – while most commonly this assessment was conducted by general Criminal Justice Social workers (who carry out court reports), there were also cases where the SA07 was completed by the MF:MC team or the police, either independently or jointly with Case Managers or with each other (i.e. the MF:MC team and Police Scotland).

The **process for determining suitability for the programme also varies between community sites**. In some sites, this is assessed through a discussion between the Case Manager and the Treatment Manager, while in others it involves discussions among a wider team (in some cases operating as a "screening panel"). Community sites generally reported that the process of assessment worked well in their own area: there was no feedback to suggest that one of these approaches was more effective than the other.

Some sex offender interventions explicitly exclude those who deny their offence ("deniers") from participation. However, the MF:MC Theory Manual states that "no offender should be refused entry to MF:MC due to denial". Practitioners from both custody and community settings nonetheless felt that deniers can have a negative impact on group dynamic. In response to this concern, **MF:MC teams within SPS have developed a specific assessment process for deniers**, which seeks to establish whether these issues can be managed within a group setting, alongside a "readiness process" which helps prepare these participants for group interaction. Community sites do not appear to have such an approach in place, and feedback from practitioners highlighted a need for further training and support on how to assess whether or not "deniers" are suitable for MF:MC.

3.2.3 Views on the assessment process: is it reaching the right men?

MF:MC is intended to target men who are rated as posing a 'high' or 'moderate' risk of re-offending. In both prison and community, eligibility for MF:MC in terms of risk-level is primarily assessed using the Stable and Acute 2007 (SA07) tool. SA07 aims to measure two sets of dynamic factors – 'acute' factors, which are characterised as environmental and intrapersonal stresses known to be related to imminent sexual reoffending and subject to potentially rapid change (e.g. intoxication, disengagement from supervision), and 'stable' factors, which are personal skill deficits or behaviours that may be addressed through treatment and supervision (e.g. substance misuse, negative peer influences, antisocial attitudes). While the SA07 tool measures both stable and acute risk factors, the MF:MC dataset only records Stable 2007 scores, since these are the factors that are considered capable of being changed through a process of "effortful intervention" (MF:MC Assessment and Evaluation manual).

Stable 2007 produces a score for each of 13 risk factors, which are then combined to classify men as high, moderate or low risk based on their Stable dynamic risk factors. The table below shows the Stable 2007 risk profile of men recorded in the monitoring data as having started MF:MC. Before commencing the programme, 68% of men were classed as moderate risk, 30% were high and only 2% were low (see Annex C, Table C.1 for breakdown by site). This suggests that, for the most part, MF:MC is successfully targeting men rated as 'high' or 'moderate' risk.

However, among Treatment Managers, there were mixed views on the effectiveness of the assessment process in identifying the 'right' men for MF:MC – in other words those who MF:MC staff felt were most likely to engage with and benefit from the programme. One view was that the assessment process works well:

> *We have a screening panel, and I think that process works well. There is full discussion about the men, their circumstances, responsivity, their offending…it's a kind of fluid process that everyone who is there takes part in.*
>
> (Treatment Manager 12)

However, a number of issues were also raised, including:

- **Whether SA07 is always completed accurately ('inter-rater reliability').** Treatment Managers and Practitioners indicated that the results of SA07 assessments sometimes varied depending on who conducted them. They cited examples of cases where MF:MC teams received referrals for men rated as 'moderate' or 'high risk' by Case Managers, but on reviewing the evidence the team considered them to be low risk, or vice versa. In part, this was attributed to the level of information the Case Manager had to make their assessment at the time.

  > *By the time we formulate a case we will have a good understanding of how he has come to commit a sexual offence, and can pick up on things that the SA07 hasn't. That's where the discrepancy lies. The assessment asks them quite intrusive questions, but it could be the first time the social worker has met the man, so he may not open up as much as he would with us.*
  >
  > (Treatment Manager 3)

  However, it was also suggested that, on occasion, Case Managers may classify a man higher on SA07 than the MF:MC practitioners would, because the Case Manager is

keen for the man to get onto the programme. In these cases, there would typically be a discussion between the practitioners and the Case Manger to agree whether or not the man is suitable for the programme. It is worth noting in this context that refresher training on SA07 was rolled out across Scotland over the last year, which may help to improve consistency between assessors.

- **Whether the content of SA07 is adequate to identify men who are suitable for MF:MC.** While overall SA07 was perceived to be a useful tool, practitioners and Treatment Managers questioned whether it fully captures all elements of risk and treatment need for this offender group. In particular, it was suggested that it does not adequately cover thinking styles and attitudinal factors that are relevant to risk, such as problematic attitudes towards child abuse or rape, or feelings of entitlement. These attitudes were considered by practitioners to be critical risk factors and key elements of the MF:MC treatment plan. Reflecting these perceived gaps, in a small number of cases, staff reported they had allowed men on the programme who were rated as 'low risk' based on their SA07 score (as discussed above, overall 2% of men recorded as starting MF:MC were classed as Low risk).

  > *Somebody might be scoring quite low, but we know that attitudinal stuff might be the key factor, and that doesn't get captured by Stable...sometimes the only way we will find out [if there are attitudinal problems] is by bringing them into the programme.*
  >
  > (Treatment Manager 9)

  The Risk for Sexual Violence Protocol (RSVP) was suggested as a possible alternative or additional tool for identifying risk factors and supporting treatment formulation.

- **The adequacy of the process for identifying whether or not internet offenders are suitable for MF:MC.** There was a broad consensus among Practitioners and Treatment Managers that the "decision tree" included in the manual was not an effective approach to assessing internet-only offenders' suitability for MF:MC. Although it was also acknowledged that there is general uncertainty about the best approach to assessing and treating internet offenders, there was a desire for greater clarity on this issue (and on alternate treatment options for those deemed unsuitable). There was concern that internet offenders who are in reality 'low risk' might be inappropriately assessed as eligible for MF:MC via the current process.

  > *There remains a lack of clarity around which internet offenders are the right offenders for MFMC and which ones aren't. If they're not suitable for MFMC, there is probably a lack of guidance or understanding around what to do with them then.*
  >
  > (Treatment Manager 11)

3.3 Programme refusal

Data on refusals is not recorded in the MF:MC IT System, since refusal would usually occur at the sentencing stage, before men are entered onto the MF:MC system. However, feedback from community sites suggests that it is rare for men to refuse MF:MC, as to do so would mean going against the requirements of their sentence.

In prison, it was estimated (by a Treatment Manager) that approximately one third of men refuse to participate in any treatment programmes, including MF:MC. SPS staff linked

refusal with either denying the offence altogether, or with men approaching parole and worrying that participation might extend their time in prison. Men interviewed for the evaluation also indicated that they had previously refused to take part in MF:MC or similar programmes in custody due to concerns about confidentiality:

> *The first time I heard about it was in [prison site] and I wouldn't do it, because everybody was talking about it in the exercise yard and pointing the finger at folk [who were on it] so I turned it down.*
>
> (MF:MC Participant 13)

Particular prisons also cited difficulties filling spaces on their groups from the national waiting list, because of a perceived reluctance among men to transfer from their current prison to a different prison. However, there was a degree of scepticism among the small number of Police Scotland stakeholders interviewed about this issue – they speculated that some men may use a reluctance to transfer prisons as an excuse to avoid participating in MF:MC.

3.4 Participation and attrition

This section uses data from the MF:MC IT system to examine the number and profile of men participating in MF:MC and the numbers leaving the programme without completing. When interpreting this data, a number of limitations should be borne in mind:

- The data is known to underestimate the total number of men who have been on the programme and the numbers who have completed MF:MC since its inception in 2014. There are three main reasons for this:
    - **A number of delivery sites began running MF:MC before the IT system was in place**, and have indicated that men who started before this point are not captured in the monitoring data.[8]
    - **The IT system's structure precludes cases from being recorded as complete until all post-programme data is available**, including the post-programme SA07, psychometrics and significant other questionnaires. Treatment Managers reported that in a number of cases men have completed all of their assigned modules, but they cannot generate a 'completion date' in their record because some of this data is missing.[9] In some cases, these men have been coded as 'removed' from the programme, but the verbatim reason given for removal is that they completed the programme but some element of the post-programme data was missing. In other cases, they may appear still to be on the programme (i.e. their cases is 'open' because of missing post-programme data, even though they have completed all the required modules).
    - **The IT system's structure means that in the event that a man re-enters MF:MC** (for example, because his treatment needs were deemed not to have been fully met), **his previous data is over-written**. The system is a record of

[8] The four sites who were delivering MF:MC before the IT system was in place indicated to the evaluation team that, across their sites, at least 50 men had started and completed the programme but were not accounted for in the data.

[9] For example, because of delays in arranging the post-programme SA07 assessment with the Case Manager (of 2-3 months in some cases); because men have refused to complete the post-programme psychometrics, or because it has not been possible to obtain a significant other interview.

where they are at on MF:MC at that point in time, but will not show whether they have fully completed a previous run of MF:MC. There may therefore be men who have completed a full round of MF:MC group-work, but are not recorded in the data as such because they have subsequently begun a new 'run' of the programme.

- **Data on the numbers leaving MF:MC is also unclear** – a number of cases are coded as having been 'removed', but the reason recorded for removal indicates they are unlikely to have started MF:MC group work in the first place (for example, MF:MC was not a condition of their sentence).

Given these limitations, the monitoring data can only provide an imperfect estimate of the number and profile of men starting, completing and leaving MF:MC.

3.4.1 Numbers participating in MF:MC

The data provided to the evaluation team includes records for 1,949 men, of whom:

- 911 men had started MF:MC[10]
- 619 did not start the programme because they were deemed unsuitable[11]
- the status of the remaining 419 is not clear from the data, but they are assumed not to have started.[12]

Of the 911 men recorded in the data as being suitable and having a start date for MF:MC, **the majority were recorded as participating in MF:MC in a community site** (81%, n = 736), with 19% (n = 175) participating in one of the four custodial sites (see Annex C, Table C.2 for a breakdown of numbers of participants by site).

The **age profile of men participating in MF:MC was fairly broadly spread** for both community and prison sites (see Annex C, Figure C.1). Younger men participating in MF:MC were more likely to be classed as High risk (38% of 16-24 year-olds) compared with older participants (20% of over 55 year-olds were assessed as High Risk based on their pre-programme Stable 2007 score) (Annex C, Figure C.2).

3.4.2 Numbers completing MF:MC

Establishing a definitive number of participants who have completed MF:MC to date is not straightforward. Leaving aside the issue of participants who are not recorded in the MF:MC IT System at all, there is no single field in the IT System which definitively records completion. Applying various possible definitions indicates that, of the 911 men recorded as participating in MF:MC, **between 230 and 266 appear to have fully completed the programme**,[13] while **97 men appear to have left the programme before completing**

[10] Based on having a start date for group work recorded in the data and being recorded as 'suitable' for the programme

[11] Men recorded as 'unsuitable', plus any men recorded as removed at risk assessment and programme suitability stage

[12] They have a programme start date, but their programme suitability is not specified.

[13] 230 have a post-programme Stable 2007 score; 242 have either a post-programme Stable 2007 score, AND/OR the verbatim 'reason for removal' recorded in the data indicates that they completed the programme; 266 appear to have completed the Managing the Future module, which is intended to be the final module completed by all MF:MC participants.

it.[14] Calculating an accurate completion rate for the programme does not appear to be feasible, both because establishing a definitive number who have completed it is difficult, and because the programme is not a fixed length (so it is not clear how many of the 911 men who started the programme should have completed it by now).

The pre-programme risk profile of men completing the programme broadly matched the pre-programme risk profile of all participants – high risk men did not appear particularly more or less likely to complete than moderate risk men.

3.4.3 Reasons for leaving MF:MC before completing

The reason for leaving the programme was not recorded for all those who appear to have left early (which again indicates potential issues with entry of the monitoring data). However, where reasons are available, the most common were: insufficient time on the man's order or time left in custody to complete; being recalled or having breached their order; and personal reasons such as poor health or change in employment circumstances (Table 3.1). In cases where men do not complete the programme in the community, the order is returned to court for resentencing. The outcome/disposal made would depend on the nature of the non-compliance and on whether the order was clearly made as a direct alternative to custody.

Table 3.1: Reason for leaving programme

Stage of removal	Number of men	% of men who left
Insufficient time on order/in custody to complete	16	16%
Recalled or breached CPO	16	16%
Personal reason (health, employment, etc.)	12	12%
Chose to leave group ('deselected')	10	10%
Other reason/unclear reason	10	10%
Removed from group	6	6%
Doing 1-1 or 2-1 work instead	1	1%
No reason recorded	26	27%
Total	97	100%

Notes to table: based on verbatim 'reasons for removal', coded into broad categories by the report authors

The stage at which 'non-completers' left the programme was not recorded for around half (48%) of the 97 who left early (see Annex C, Table C.3). Of the remainder:

[14] Based on all men who have a date of removal from the programme, excluding any whose 'reason for removal' was due to 'successful completion', who were removed at the risk assessment stage, or who had another 'reason for removal' that indicated they never started MF:MC group work (e.g. MF:MC was not a condition of their sentence).

- 5% were classed as leaving at the point of pre-programme psychometrics, and therefore had not actually commenced any group work
- 38% left during group work (28% during Essential and 10% during Optional modules), and
- 8% were recorded as leaving at the post-programme stage (either psychometrics, risk assessment of exit interview).

3.5 Engagement

Engagement with an intervention can be assessed on a number of levels: the level of attendance at sessions; the extent to which men actively take part in and contribute to sessions; and the extent to which they are deemed to be "genuinely" engaging with treatment in terms of their motivation to change (which is, of course, more difficult to accurately gauge).

Practitioners reported that in general, attendance on MF:MC was very high and that it was rare for men to miss any meetings. This finding was supported by interviews with men who, for the most part, said that they had not missed any MF:MC group sessions unless there were exceptional circumstances that they could not avoid.

In terms of specific stages of MF:MC where men might be less engaged, some participants indicated that they had felt less motivated to engage at the beginning, because they felt uncertain about what to expect or worried about discussing their offence and their lives in a group setting. In general, these fears appeared to have been allayed relatively early in the programme after meeting with staff and attending the initial group meetings. After any initial concerns had been addressed, men generally reported feeling strongly engaged with MF:MC throughout the duration of their time on it (although, as discussed above, the repetition of concepts when new participants 'roll on' to MF:MC was associated by both staff and participants with some waning attention among other group members). Among men who had taken part in custodial settings, there were also examples of some continued reluctance to engage openly in group discussions due to a perceived lack of confidentiality.

> *[In prison], as soon as you disclose anything that someone didn't know that was it. By the time you get back to the hall, the whole hall would know what you'd been saying at the groups.*
>
> (MF:MC Participant 7)

The monitoring data also includes MF:MC Practitioners' assessment of how engaged participants were in group sessions for each module they have completed. As shown in Table 3.2, across most modules, most participants' attitudes were rated as 'supportive', with around 20-25% 'neutral' (presumably indicating that their level of genuine engagement was difficult to gauge). Very few participants (3% or less for each module) were recorded as displaying 'non-supportive' attitudes within group sessions. The only module where a higher proportion were recorded as 'neutral' rather than supportive was the 'social support' optional module. However, as this is only based on data for 78 men, some caution should be applied in extrapolating from this to the conclusion that participants are less engaged with this module.

Table 3.2: Perceived engagement by module

		Neutral	Non-supportive	Supportive	Base (number of men with record of engagement for that module)
Essential modules					
Entry module	%	25	3	72	540
Re-entry module	%	24	2	74	42
Introduction to Thinking Styles and Self-Management	%	20	3	78	476
Essential HSF module	%	22	2	76	456
Discovering Needs	%	18	3	79	404
Moving to the Future	%	17	3	81	352
Optional modules					
Motivation	%	30	0	70	23
Social support	%	39	3	59	78
Relationship skills	%	20	2	78	130
Self-management	%	21	2	77	145
Thinking Styles	%	24	3	74	144
HSF	%	21	2	77	343
Empathy & Perspective Taking	%	23	0	76	56

Overall, programme participants and staff both felt that engagement was primarily influenced by an individual's own motivation, rather than programme stage, offence type, age or cognitive ability.

3.6 Suggestions for improvement

Feedback from interviewees and analysis of monitoring data outlined above indicates a number of potential areas for improvement. First, in terms of the assessment process, there is a need to:

- **Review the process and guidance for assessment of internet offenders.** Work that may inform this is already underway – the Risk Management Authority have been commissioned to carry out a review of international research literature on internet offending, and to look at the trajectories of online sexual offenders in Scotland. This research is due to report in Summer 2018. In light of the lack of

current consensus over the most appropriate approach to treatment of internet-only sex offenders, there is also a need to ensure that any guidance on this issue is kept up to date in light of new evidence.

- **Consider whether further guidance or training on completing SA07** is required, to address the issues around inter-rater reliability and accuracy identified by MF:MC staff and treatment managers.
- **Consider whether or not additional tools (e.g. RSVP) are required to supplement the SA07 as a tool for identifying and formulating treatment plans for offenders** who may be suitable for MF:MC, in light of perceived gaps in the information captured by this tool.
- **Provide further guidance on assessing deniers** for suitability for MF:MC, perhaps drawing on the system already established in SPS.

In terms of suggestions for increasing engagement in the programme, potential changes (some of which have already been identified in Chapter 2) include:

- **Considering ways of reducing repetition**, particularly when new men 'roll on' to groups
- **Increasing the frequency of sessions in the community**, to reduce the length of time men have to wait before they are 'in focus' discussing their assignments.
- **Providing further guidance on managing deniers** within MF:MC, to avoiding the risk of disruption to the rest of the group (which could undermine other participants' engagement).

In general, the difficulties accurately identifying numbers starting, leaving early, and completing the programme indicate a need to review how these outcomes are captured within the monitoring data. One possibility would be to incorporate a **single 'Final programme status' field**, to be completed for every case but which is not dependent on completion of other post-programme data. This field should (provided data is being entered regularly) then be up to date for those who either did not start, left early, or have completed all required modules at any given point in time.

There is also a need to **gather clearer data on programme attrition** (given that the 'reasons for removal' field currently appears to include a number of cases that either did not start the programme or completed successfully), **and to monitor this** as the programme develops, to ensure that mitigating actions can be put in place.

4. Programme outcomes

Key findings

Limitations to outcomes data

- There are significant limitations to the data available to assess outcomes from MF:MC:
    - The **lack of a control group** means it is not possible to conclusively attribute any changes observed to the impact of MF:MC
    - There are perceived issues around **inter-rater reliability**, **validity** of selected outcome measures, and **high levels of missing data**
    - Qualitative interviews with participants were **limited in terms of the number of case study sites** (5 of 15) it was possible to visit, and were arguably **unlikely to reveal potential *negative* impacts** from the programme.

Quantitative outcome measures

- Although changes cannot be conclusively attributed to MF:MC, the quantitative data does indicate a number of **positive changes in participants**:
    - **A reduction in risk scores over the course of the programme**. 69% saw some level of reduction in their risk score (although in 10% of cases, risk scores increased, albeit typically by only 1 or 2 points).
    - **Positive changes in scores measuring a range of psychological traits** potentially associated with risk factors for re-offending.
    - **Men expressed positive views about its impact**. 85% of men who completed an exit survey on leaving MF:MC said they thought it would stop them re-offending in a similar manner.

Staff, participant and stakeholder perceptions

- MF:MC staff and Case Managers found it **difficult to assess what impact MF:MC is having**. However, overall they felt that feedback from men, significant others, other professionals, and their own observations indicated that it was having a positive impact. It was also suggested that the design of the programme meant it had a **"better chance" of being effective than previous programmes**. The small number of Police stakeholders that we interviewed, however, were more sceptical about its likely impact, questioning whether participants might project an overly positive picture of their progress within MF:MC groups.
- Participants and staff gave **examples of where they believed MF:MC had impacted** on men's ability to develop and sustain healthy social relationships, to regulate their emotions, to co-operate with supervision, and to understand and change problematic attitudes. The programme's impact on sexual self-regulation was more difficult to explore and the evidence on perceived impacts more mixed, however.
- Key features participants perceived may be contributing to perceived positive impacts were the fact that it was **group based** and the **overall theoretical approach**. Views on whether specific modules and approaches were particularly helpful varied, but the **Thinking Styles**, **Self-management** and **Relationship** modules were singled out by participants as particularly useful.

- Overall the ability to tailor MF:MC to different needs was praised. However, Treatment Managers and Practitioners **identified a number of groups of men whose needs they felt were not fully met by MF:MC at present**, including men with: Personality Disorder and/or acute emotional difficulties; early maladaptive schemas; Autistic Spectrum Disorder, and men who are Internet offenders; paedophiles who view their sexual pre-occupation with children as an acceptable orientation; commit sexual offences in a relationship; or have already completed multiple interventions.
- Various suggestions were made as to how the programme might be strengthened or adapted to meet some of these needs. However, there was also a perception that at present MF:MC is **expecting delivery staff to have an unrealistically wide range of knowledge and skill** across diverse psychological approaches and presenting needs, and that this needs to be re-examined going forward.

4.1 Introduction

This chapter explores MF:MC programme outcomes. It summarises the key outcomes the programme is intended to influence and discusses what data is available to assess whether or not these have been met. Quantitative monitoring data are used to look at **distance travelled** with respect to indicators of dynamic risk factors and psychological traits, while qualitative data from participants, staff and stakeholders illustrate **perceived impacts**.

In addition, the chapter:

- examines views on the key factors influencing programme impact, including aspects of the programme design and delivery, and factors external to the programme
- considers whether or not the programme is believed to be effective in meeting the needs of diverse participants, and
- outlines a number of suggestions for improvement aimed at enhancing programme impact and improving the measurement of impact.

4.2 What outcomes is MF:MC intended to influence?

The MF:MC Theory Manual describes the programme as aiming “to assist participants to lead a satisfying life that does not involve harming others”. In other words, it attempts to develop participants’ skills and capacities to achieve ‘primary goods’ (including happiness, community and relationships) in positive, pro-social ways, which should, in turn, reduce their risk levels. As already noted, the precise goals of the programme will vary depending on the assessed needs of each participant (determined during the formulation stage). However, the overall treatment targets have been mapped onto the static dynamic risk factors identified in the Stable 2007 risk assessment protocol, and include:

- **Significant social influences** –the Social Support module aims to help participants develop a social network of individuals likely to “promote pro-social values, encourage self-control strategies, and provide material and emotional support” (Theory Manual, 2014: 58)
- **Intimacy deficits** – the Relationship Skills and/or Thinking Styles modules address a range of intimacy deficits which are characteristic of sex offenders, including capacity for relationship stability, emotional identification with children, hostility towards women, general social isolation/loneliness, and lack of concern for others

- **General self-regulation** – the Self-Management and/or Thinking Styles modules address issues around general self-regulation (which has been shown to be associated with re-offending), including impulsive behaviour, poor problem-solving, and negative emotionality and hostility (feeling hostile, victimised and resentful)
- **Sexual self-regulation** – sexual deviancy and sexual pre-occupation have been found to be strong predictors of sexual recidivism. Both are addressed in the Healthy Sexual Functioning and/or Self-Management modules.
- **Co-operation with Supervision** – non-compliance with supervision is one of the best predictors for sexual and non-sexual recidivism. The Managing the Future module aims to help participants engage meaningfully with those involved in their case management.

In addition, MF:MC also aims to influence three other key risk factors, which are not covered by Stable 2007:

- **Attitudes** – the Thinking Styles and Victim Empathy/Perspective Taking modules challenge 'cognitive distortions' believed to play a role in sex offending, such as beliefs of entitlement, rape supportive attitudes, and child abuse supportive attitudes
- **Victim empathy and perspective taking** – although the link between victim empathy and reoffending is disputed in the literature (Hanson and Yates, 2013), the MF:MC Theory Manual indicates that most programmes include some work on this issue on the basis of it "being an appropriate way to achieve attitude change" (2014: 65).
- **Motivation** – evaluations of other sex offender interventions indicate that developing skills and strategies to avoid reoffending is not enough if participants are not fully motivated to change. The Motivation module of MF:MC aims to increase participants' motivation to develop pro-social behaviours.

4.3 What data is available to assess MF:MC outcomes?

This evaluation makes use of two main sources of data to explore MF:MC outcomes: quantitative data taken from the MF:MC IT system, which records data for each man referred to the programme, and qualitative data derived from interviews and workshops conducted by the evaluation team with Treatment Managers, Practitioners, men who have participated in MF:MC and stakeholders. In discussing and interpreting these two sources of data, it is important to be clear about their limitations.

4.3.1 Quantitative data

There are a number of measures included in the MF:MC monitoring data that could be used to examine outcomes:

- **Pre- and post-programme Stable 2007 scores** can be used to assess changes in the assessed risk level of men participating in the programme
- **Pre- and post-programme scores across 8 psychometric scales** can be used to assess any changes in specific psychological traits believed to be associated with risk of sex offending (details of the scales included are provided in section 4.4)
- **Data from an 'exit interview' with participants**, which asks them to comment on the perceived impact they believe MF:MC has had in a number of areas, including whether or not they feel it will stop them re-offending in a similar manner.

- **Data from a 'significant others' questionnaire**, administered at the end of the programme, provides an indication of whether other people have observed any changes in participants.

As discussed in Chapter 1, the extent to which any conclusions about impact can be drawn from the quantitative data collected for MF:MC is severely limited by the lack of a control group: without a sufficiently large comparator group of men who have not been through MF:MC, it is not possible to establish that any observed changes are a result of the programme.

In addition, interviews with Treatment Managers and Practitioners also identified a number of concerns about the validity and/or reliability of each of the quantitative measures identified above.

- In principle, **Stable 2007** was believed to be a valid tool for establishing 'stable' dynamic risk factors (although, as discussed in Chapter 3, it was suggested that it did not capture all relevant risk factors). However, as noted, Treatment Managers and Practitioners expressed **concerns about inter-rater reliability** and accuracy of completion. It was suggested by Prison Treatment Managers that social workers completing SA07 were often basing their assessments on a fairly brief interview with the man, rather than drawing on all the available evidence (for example, feedback from other staff) that might enable them to assess dynamic risk.
- With respect to the eight **psychometric scales** administered before and after the programme, MF:MC teams **questioned the validity** of some of the scales selected for use with sex offenders, particularly the 'Hostility towards women' and 'Sex with children is justifiable' scales. While one view was that **social desirability bias** is an inherent problem with psychometric scales, these scales were considered particularly poor in this respect – it was suggested it was "*transparent*" what answers men were "*meant*" to give. These views are echoed in academic debate about the use of psychometrics – for example, Russell and Darjee (2013) argue that psychometric tests for use with sex offenders are:

  > "transparent and prone to self-report bias. There is conflicting evidence on the relationship between self-report psychometrics and recidivism … Changes in scores may or may not indicate a reduction in risk, but there is little reliable evidence that such measures indicate whether there has been positive change with treatment or whether risk has reduced" (2013: 59).

  Discussion at the workshop also revealed apparent differences in the way in which psychometric tests were administered between sites – whether men were simply given the tests to complete themselves, or whether they were supervised by MF:MC staff, or completed them with MF:MC staff. These differences in administration may have implications for the consistency of this data between sites.
- There is a **relatively high level of missing data for the 'exit interview'** with participants – 161 men completed it (compared with 230 men for whom there is a post-programme Stable 2007 score). It is also obviously reliant on participants' self-report, which cannot on its own be regarded as a reliable outcome indicator, particularly with respect to perceived risk of re-offending.
- There is also a **high level of missing data and 'unknown' responses for the significant others questionnaire**. Moreover, the questionnaire was considered problematic as an outcome measure because in a significant proportion of cases, particularly for men in prison, there was **no non-professional who felt able to**

complete it. Staff reported that in some sites, this questionnaire was completed by MF:MC practitioners based on their own observations instead. However, this means that the data is inconsistent (professional judgements may be very different from those of friends or family members), and there appears to be no way of establishing from the dataset who completed individual questionnaires.

Given these concerns, significant caution must be applied in interpreting any findings about 'distance travelled' by participants on the programme based on this data. The end of this chapter includes a number of suggestions about potential improvements to the outcome measures collected for MF:MC going forward.

4.3.2 Qualitative data

The aim of qualitative sampling is to identify the nature and range of views on and experiences of a particular programme or issue. However, as noted in Chapter 1, while the evaluation included staff from across all 15 MF:MC delivery sites, it was not possible to include participants from every site, and we were only able to interview a limited number of stakeholders within the evaluation timescale and resources. As such, there may be other views on programme impact that are not captured here.

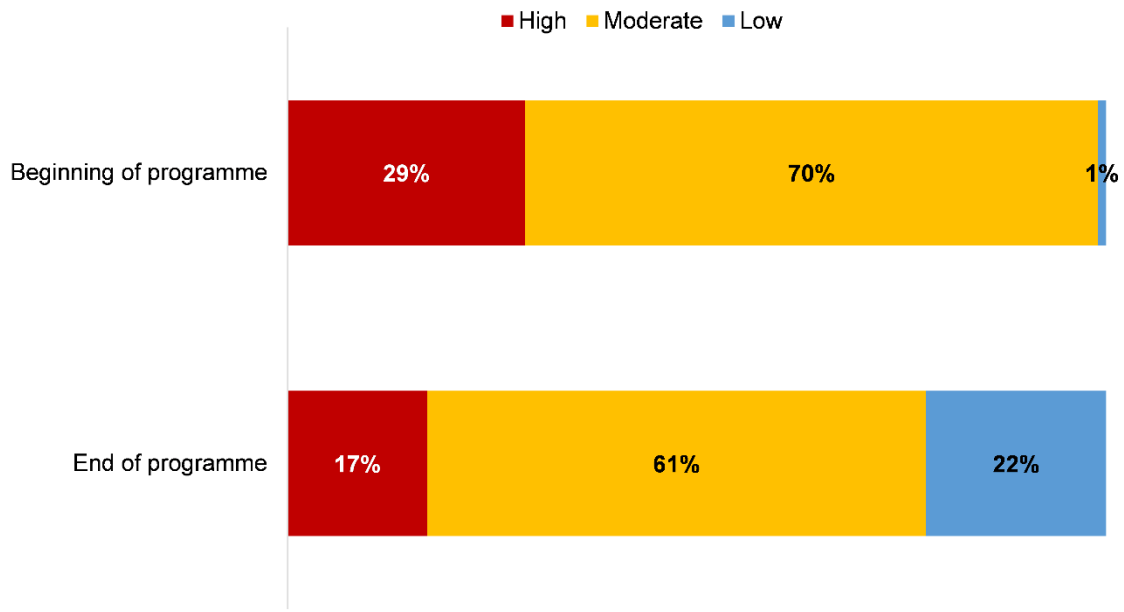
In addition, as discussed in Chapter 1, participants who were motivated to agree to an evaluation interview are also likely to be those relatively more motivated to participate in MF:MC. Moreover, although researchers emphasised to MF:MC participants that the purpose of the interviews was to assess the programme not its participants, it is arguably unlikely that offenders would reveal anything in a research interview that might suggest they felt their risk had *increased* in particular areas. As such, while interviews with participants can help identify perceived positive impacts and suggestions for improvement, they are less likely to be able to identify any areas where the programme is having a *negative* impact on key treatment outcomes.

4.4 Quantitative outcome measures: distance travelled

4.4.1 Overall risk profiles

As noted in Chapter 3, the 'Stable' scale produces a score for 13 risk factors, with a score of either 0 (suggesting no need for intervention), 1 (possible need for intervention), or 2 (definite need for intervention) on each one, resulting in an overall maximum score of 26. Those scores are then banded into "High", "Moderate" or "Low" risk categories. As shown in Figure 4.1, across the 230 men for whom there was both a pre- and post-programme Stable 2007 score in the monitoring data, there was a significant shift in overall risk profiles from the beginning to the end of the programme: **the proportion of men classified as high risk decreased from 29% to 17%, while the proportion of men classified as low risk increased from 1% to 22%.**

Figure 4.1: Stable 2007 Bands at beginning and end of programme



Base: All with SA07 scores at both beginning and end (230)

This change in risk level can also be illustrated by looking at the difference between individual Stable 2007 scores at the beginning and end of the programme, expressed as either a positive or negative figure (a negative figure representing a reduction in the risk score, a positive figure representing an increase). **The majority of men (69%) saw a reduction in their overall Stable 2007 risk score** (although in some cases this reduction was not sufficient to move them from 'high' to 'moderate' or from 'moderate' to 'low'), while **20% saw no change in their scores** and **10% saw their risk scores increase**. Among the 10% who exhibited an increase in their Stable 2007 score, in most cases this was only by 1 or 2 points (within a maximum score of 26).

Table 4.1 shows movement between risk bands pre to post-programme in more detail – among the 66 men rated as high risk based on their Stable 2007 scores at the start of MF:MC, 53% remained high risk at the end of the programme, while 38% had moved into the 'moderate' category and 9% were rated low risk. Among the bigger group (161 men) initially rated 'moderate' risk, most (72%) remained in this category, but 26% moved into the 'low risk' category, while a small number (3%, n=4) were rated 'high risk' at the end of the programme.

Table 4.1: Post-programme Stable 2007 scores by pre-programme Stable 2007 score

Pre-programme Stable 2007 score	Post programme Stable 2007 score			
	High (12-26)	Moderate (4-11)	Low (0-3)	*Base*
High	35	25	6	*66*
	53%	38%	9%	
Moderate	4	116	41	*161*
	3%	72%	26%	
Low	-	-	3	*3*
	-	-	100%	

Base: All those with a Stable 2007 score at beginning and end of programme (230)

The average reduction in mean SA07 scores from pre- to post-programme was -2.7 (from 9.5 to 6.8 out of a maximum of 26). However, those starting with a High Stable 2007 score reduced more than those starting with a Moderate score (by 4 points compared with 2.2 - see Annex C, Table C.4). These findings suggest that **men who are 'high risk' at the start of MF:MC are more likely to see their risk levels reduce, and by a bigger margin**, over the course of the programme.

The reduction in mean Stable 2007 risk scores was also bigger for men who participated in MF:MC in community sites compared with those who took part in prison, across those for whom a pre- and post-programme score was available. There was no significant variation by age group (see Annex C, Table C.4).

4.4.2 Changes in specific risk factors

As discussed above, Stable 2007 produces scores for 13 specific risk factors, around which much of the content of MF:MC has been designed. Table 4.2 shows the mean scores pre- and post- completion of MF:MC for each individual factor (from a minimum of 0 to a maximum of 2). While on average scores reduced pre- to post-programme on each individual risk factor, the mean reduction was greater for some than others:

- 'Sex pre-occupation', 'General social rejection/loneliness', 'Sex as coping' and 'Poor cognitive problem solving skills' were the categories that saw the biggest reductions in mean scores
- 'Co-operation with supervision' and 'Capacity for relationship stability' were the categories that reduced the least.

The mean score for cooperation with supervision was, however, relatively low at both the start and end of the programme. In contrast, 'Capacity for relationship stability' was one of the higher scoring risk factors at both the start and end, suggesting both that this is relatively more likely to be rated a risk factor for men participating in MF:MC, and that the average level of risk men present on this factor is less likely to change over the course of participation. Two attitudinal risk factors – emotional identification with children and

hostility towards women – also reduced less on average from pre- to post-programme, although this largely reflects the fact that most men scored '0' both pre- and post-programme on these measures, so the mean score at both points was relatively lower than for other risk factors.

Table 4.2: Mean score for each Stable category, pre and post-programme

	Mean score pre programme (Between 0-2)	Mean score post programme (Between 0-2)	Mean Change in score	*Base*
Social influences	0.79	0.63	-0.16	*230*
Capacity for relationship stability	1.31	1.24	-0.07	*231*
Emotional ID with children (1)	0.27	0.16	-0.11	*183*
Hostility towards women	0.31	0.21	-0.10	*231*
General social rejection/loneliness	0.95	0.61	-0.34	*230*
Lack of concern for others	0.52	0.31	-0.21	*230*
Impulsive acts	0.50	0.30	-0.20	*230*
Poor cognitive problem solving skills	0.92	0.61	-0.31	*230*
Negative emotionality/hostility	0.65	0.43	-0.22	*230*
Sex preoccupation	0.80	0.45	-0.35	*230*
Sex as coping	0.67	0.36	-0.31	*230*
Deviant sexual interests	1.40	1.19	-0.21	*230*
Co-operation with supervision	0.42	0.36	-0.06	*230*

Base: All those with a score at beginning and end of programme

Notes to table:

1 – the difference in the base for this measure is largely accounted for by men who were either rated 0 at the start of the programme and 'not applicable' at the end, or for whom the measure was deemed 'not applicable' both pre- and post-programme

Although most men saw a reduction in their risk scores, it is worth noting that there are question-marks over the reliability of the risk data.

4.4.3 Changes in psychological traits

The psychometric tests administered before and after participation in MF:MC are:

- **The Self-Compassion Scale**, designed as a technique to assist men in regulating emotional responses to triggering situations, as negative emotionality is a risk factor included in the SA07. The higher the score on the Self-Compassion scale, the more likely that someone is self-compassionate. The lower the score, the more likely someone needs to work on developing compassion for self. MF:MC is intended to

increase men's self-compassion, as part of addressing intimacy deficits and self-regulation.

- **The Social and Emotional Loneliness Scale for Adults (SELSA)** is measured on three levels: romantic, family and social loneliness. MF:MC attempts to encourage participants to build healthy social networks and to develop their relationship skills, which should in turn reduce social and emotional loneliness.
- **Social Problem Solving Inventory (SPSI)**. As discussed above, problem solving skills are a key element of general self-regulation, targeted by the Thinking Skills and Self-Management modules in particular.
- **Levenson Locus of Control (LOC)**, measures the extent to which individuals feel in control of their lives. It is made up of three sub-scales relating to: internality (the extent to which people believe they have control over their lives); powerful others (the extent to which people believe that powerful others control their lives); and chance (the extent to which they believe chance affects their lives). Encouraging participants to take control of their lives is a general theme within MF:MC and the Good Lives Model, which encourages participants to identify appropriate life goals and develop skills and strategies to achieve these.
- **Barratt Impulsiveness Scale** assesses nine factors associated with impulsivity, with high scores being used to classify someone as highly impulsive. Impulsivity is another risk factor addressed as part of attempting to improve participants' general self-regulation.
- **Hostility Towards Women Scale**, included to measure problematic attitudes towards women.
- **Sex with Children is Justifiable Scale**, included to measure the presence of child abuse supportive attitudes.
- **Paulhus Deception Scale** which measures: impression management (the tendency to purposefully describe oneself in overly positive terms) and self-deception (the tendency to attempt to be honest but still exaggerate positive virtues).

The potential limitations of psychometric scales in general and of a number of these scale in particular have already been discussed. However, insofar as any limitations are likely to apply equally to both the pre- and post-programme measures, examining any change in scores over the course of the programme *may* provide some indication of whether participants have experienced change in these psychological traits.

On each psychometric scale, **the majority of men had either shown improvement or stayed at the same level over the course of the programme** (Table 4.3). Across most scales, 5% or less recorded a worse score at the end of the programme than at the start. However, this figure was slightly higher for the 'self-compassion scale' and 'social problem solving inventory' – 9% and 12% respectively recorded lower scores post-programme on these scales.

Table 4.3 shows what proportion of men have scores that are higher or lower by any amount post-programme compared with pre-programme. In some cases, these changes may have been too small to indicate meaningful change. However, it is worth noting that the change in scores pre to post programme tended to be smaller, on average, among those recording a worse score post-programme than among those recording an improvement in scores. For example, the mean improvement in scores (within a possible range of 12-60) on the 'self-compassion' scale was 34 points, while the mean change

among those whose score got worse was 12 points (see Annex C, Table C.5). So the scale of 'decline' among those men who recorded a worse score post-programme tended to be smaller than the scale of improvement among those men who recorded a better score.

Table 4.3: Change in scores on psychometric scales pre and post-programme

	Improved	Stayed the same	Worse	*Base*
Self-Compassion Scale	36%	54%	9%	*228*
Social Problem Solving Inventory	35%	54%	12%	*205*
Social and Emotional Problem Solving Scale for Adults (SELSA)				
SELSA 1 – Romantic (Loneliness/struggling with romantic relationships)	38%	58%	4%	*205*
SELSA 2 – Family (Loneliness/struggling with family relationships)	42%	56%	2%	*205*
SELSA 3 – Social (Loneliness/struggling with social relationships)	42%	55%	2%	*205*
Locus of Control (LOC)				
LOC 1 – Internality (Belief that I control my life)	39%	54%	7%	*205*
LOC 2 – Powerful others (Belief that powerful others control my life)	41%	55%	3%	*205*
LOC 3 – Chance (Belief that my life is controlled by chance)	21%	74%	5%	*205*
Barratt Impulsiveness Scale	42%	55%	3%	*205*
Hostility Towards Women Scale	22%	75%	2%	*205*
Sex with Children is Justifiable Scale	18%	81%	1%	*205*
Paulhus Deception Scale	34%	60%	5%	*205*
Self deception	27%	66%	7%	*205*
Impression management	35%	57%	7%	*205*

The scales on which the highest proportion of men recorded an improvement were *SELSA 'Family'* (42%) *and 'Social'* (42%), the *Barratt Impulsiveness scale* (42%), and *LOC 'Powerful Other'* (41%). Improvements in 'family' and 'social' isolation as measured by

SELSA broadly tally with the finding above that 'general social rejection and loneliness' is one of the Stable 2007 risk factors that reduces most, on average, for MF:MC participants over the course of the programme. The other findings suggest that participants may also be relatively more likely to experience reductions in impulsiveness and to become less likely to view their lives as controlled by powerful others by the end of the programme.

In terms of both the *Hostility Towards Women* and *Sex with Children is Justifiable* scales, more than three quarters of men stayed at the same level between the beginning and end of the programme. However, this largely reflects the fact that scores on each of these scales tended to be low to begin with – so there was less scope for improvement. This may reflect the fact that these scales are not likely to be equally relevant to all categories of sex offender (for example, men who are not paedophiles would be expected to score low on the 'Sex with children is justifiable' scale at both pre- and post-programme stage). There were very few statistically significant differences between prison and community sites or between men with different pre-programme risk levels. The few differences that did exist did not point in a clear direction, so are not reported here.

4.4.4 Perceived outcomes based on participant 'exit survey'

A majority of the 161 men who completed an exit survey expressed positive views on the impact of MF:MC across a range of measures (Table 4.4). Over 80% in each case said that MF:MC had: helped them learn skills that would help them to deal with other problems (89%); that the programme met their needs (87%); and that it had help them to understand better why they committed their offence (83%). Participants were slightly less likely to report positive changes in their family relationships, though a majority (72%) reported that these had improved since taking part in MF:MC. In terms of perceived impact on offending behaviour, although 85% said MF:MC would stop them re-offending in a similar manner, 10% said it would not (although this does not necessarily imply they think they will re-offend – just that they do not think MF:MC has influenced this), and 5% were not sure.

Table 4.4: MF:MC participant exit interview responses

	Yes	No	Unsure
Do you think MF:MC will stop you reoffending in a similar manner?	85	10	5
Do you think that MF:MC met your needs?	87	7	6
Do you think that the programme helped you to understand better why you committed the offence?	83	12	6
Have there been any positive changes in your family relationships since taking part in MF:MC?	72	19	9
Do you think that the skills you learned in MF:MC will also help deal with other problems and difficulties in life that you have?	89	7	4
Would you recommend other people who have committed sexual offences take part in MF:MC?	90	5	6

Base: All who completed an Exit Interview (161)

4.4.5 Perceived impact based on the 'significant others' survey

Across all the measures included in the 'significant others' survey (which, as noted above, was completed by either a family member/friend or by an MF:MC practitioner), very few of the 119 respondents (under 5% in each case) reported observing negative changes in participants since they took part in MF:MC. However, in each case a high proportion of responses (48-53%) were coded "unknown". It is unclear if this is because the respondent felt unable to comment on whether the participant had changed with respect to the behaviour asked about, or whether no significant other was available to complete the survey.

The areas with the highest proportion of respondents reporting positive changes were:

- men's considerations for the feelings of others (38% saw positive changes)
- their motivations to develop pro-social behaviours (37%)
- their relationship with the significant other (36%), and
- their ability to cope with significant life stress (34%).

Lower proportions reported observing positive changes in:

- the extent to which men felt comfortable with adults (27% reported a positive change but 23% saw no change)
- the extent to which they have the skills to establish and maintain an intimate, live-in relationship (23% reported a positive change but 21% reported no change), and
- their capacity to make friends and be with others (28% reported a positive change, 20% no change).

However, where 'significant others' observe 'no change', it is unclear whether or not they believed this was an area where the man had issues at the beginning of the programme that needed to be addressed – in other words, 'no change' could imply a continuation of a problem, or that this was not an area the significant other considered problematic in the first place.

Table 4.5: Results of exit interviews with significant others

What changes, if any, have you observed in the participant since they were on MF:MC?	**Positive**	**No change**	**Negative**	**Unknown**
Relationships				
Relationship with me	36%	15%	1%	48%
The capacity to make friends and be with others	28%	20%	3%	49%
The skills to establish and maintain an intimate, live-in relationship without any obvious problems	23%	21%	4%	53%
Interaction				
Interaction with people in the community	30%	20%	2%	48%
Feels comfortable with adults	27%	23%	2%	48%
Behaviours				
The motivations to develop pro-social behaviours	37%	11%	3%	50%
Consideration for the feelings of others and behaves in a caring manner	38%	13%	1%	48%
The ability to cope with significant life stress	34%	13%	3%	50%

Base: All with data for a significant other interview (119)

4.5 Staff, participant and stakeholder perceptions of impact

4.5.3 Participants' expectations of MF:MC

The MF:MC participants we spoke to did not always have a clear idea of what MF:MC would involve prior to starting on the programme, reporting that they were either told very little in advance, or had struggled to take in what was involved because of their unsettled state of mind at the time. A degree of initial scepticism about the programme was apparent from men who said they had not felt they needed to attend and had only agreed because it was a condition of their license or parole. However, men also described positive hopes for participation in MF:MC, including hoping it would help them change in general, gain a

better understanding of themselves and/or the reasons they offended, and help to prevent them reoffending by developing strategies to cope better with the factors that led up to the offence. Overall, Men's expectations of the MF:MC appeared to reflect programme aims.

4.5.4 Overall perceptions of impact

The dominant position among Treatment Managers and Case Managers interviewed for this study was that it is extremely difficult to judge exactly how effective MF:MC actually is in reducing the likelihood of reoffending. Professional comments on the challenges of making a robust judgement on impact reflected many of the general evaluation challenges already discussed in this report: men might not come back to custody or re-enter the community programme, but short-term re-offending rates are low; Stable 2007 scores might reduce, but you would expect this to happen even if they were just on ordinary supervision; and it is difficult to separate out the impact of MF:MC from the MAPPA system as a whole.

However, in spite of this lack of certainty, the overall perception among Treatment Managers, Practitioners and Case Managers was that MF:MC is having a positive impact. They based this on feedback from men, significant others, other professionals (Case Managers and Supervising Officers) and on their own observations of behavioural change occurring (to varying degrees) among participants. A Case Manager described seeing someone on a three-year order "*develop into a whole different person … even the way they hold themselves and their body language*" when on MF:MC. Treatment Managers and Case Managers also said they felt it was a more evidence-based programme than previous sex offender interventions. As such, even when they felt unable to comment definitively on impact, they felt it had a *"better chance"* of being effective:

> *There isn't any data to show its effectiveness. But my view, having worked on various sex offender programmes, in various settings, to me this is by far the most effective in relation to getting the engagement with the men, enabling the men to understand their offending behaviour and why they're doing what they have been doing, and planning for the future … We've certainly got positive feedback from Case Managers as well, who are seeing the difference in their guys.*
>
> (Treatment Manager 8)

The three stakeholders from Police Scotland, in contrast, were less convinced MF:MC was having a positive impact – they felt that men may present themselves differently in a group setting and know how to say the "right things" even when they actually go on to reoffend.

Professionals again reiterated the view that the overall impact of the programme will in large part depend on participants' own motivation – "*it can be effective if the individual wants to change"* (Treatment Manager 10).

Perceptions of MF:MC among the participants who had completed MF:MC were extremely positive. They reported that it had not only helped them address their behaviour, but also to understand the reasons for it and to develop a better understanding of themselves:

> *It helps you discover things you never knew about yourself; look at yourself in a different way; all aspects of your life, not just your offences. If you give it a chance, you will get the benefits from it.*
>
> *(MF:MC Participant 12)*

4.5.5 Perceived impacts on treatment targets

Participants and staff also gave examples of the ways in which they thought MF:MC had impacted on the specific treatment targets described above (section 4.2).

- **Social influences and intimacy deficits** – MF:MC staff and Case Managers reported observing men displaying better social skills (within and outwith groups) and overcoming social anxieties, while participants described having better, more open relationships with family and friends and feeling less socially isolated. Participants attributed these perceived changes both to the Relationships module specifically, and to a belief that MF:MC had made them more confident (via the group work process), compassionate, and/or helped them redress their priorities to focus more on family and friends in general.

  > *At first I was a bit shy, I fell back, I didn't know if I could trust them (the group) with what I was saying. … (Now) I feel more relaxed because I have known them, now they are always up front with me. … So, I'm more open, I like to talk to them and be up front.*
  >
  > *(INTERVIEWER) ...does that go to you like outside the group as well?*
  >
  > *Yes, it does, yes, … since I've been in this one (relationship), I feel more relaxed and honest, we're doing a lot more things together, we have not actually had any arguments in this relationship at all so far, we are really like a family*
  >
  > (MF:MC Participant 16)

- **General self-regulation** – Participants reported that MF:MC had helped them to approach problems in a better way – to step back and assess situations rather than acting on impulse – and to gain better control of their emotions (particularly with respect to managing their anger). For example, one participant who had recently lost a job felt he had responded to this very differently in comparison with the past:

  > *I don't feel that I'm as hung up on things any more. I don't constantly ruminate on it, I'm moving on, I'm saying to myself, "okay, it's happened how do we move forward and what can I do to get into work?" So, being more practical, being more task focused about things rather than being emotionally focused and getting caught up and hung up about things that's went on in the past.*
  >
  > (MF:MC Participant 9)

  Participants also reported changes in their outlook indicating a reduction in 'negative emotionality' – that they no longer saw the world as a "*threat*" or a *"bad place"*.

- **Co-operation with supervision** – Participants gave examples of where they had used techniques learned in MF:MC to manage meetings with social workers in a calmer fashion, indicating that the programme can help support better engagement with supervision:

  > *Before I used to always have problems communicating with them (social worker) and actually getting my point across. Since I've been down here it*

> *makes it a lot easier because I can now see things from a slightly different perspective and it makes it easier just to get the point across to them. (…) Less heated, less heated, because quite a lot of times normally ended up in an argument, so it definitely has been a big change in the way I actually deal with them now.*
>
> (MF:MC Participant 14)

- **Attitudes and empathy** – Participants described MF:MC as challenging and increasing their understanding of problematic attitudes – for example, a participant with learning disabilities described gaining a better understanding of what 'entitlement' is and why it is wrong from the programme, while another said it had taught him to see women as equals when he had previously viewed them as existing for his benefit. Empathy tended to be discussed in general terms (for example, developing more compassion for other people and themselves, or learning empathy from being in a group) rather than specifically with respect to victims. However, participants reported that MF:MC had helped them understand how many people were affected by their actions (and specifically by their offence).

The perceived impact of the programme on **sexual self-regulation** was more difficult to ascertain. It was not appropriate to delve into this area within a one-off interview with participants, although there were examples where participants indicated feeling they had gained a better understanding of issues around sex and healthy/unhealthy sexual thoughts. Among Treatment Managers and Practitioners, while one view was that MF:MC tackled sexual function more effectively than previous programmes, there was also some concern about whether aspects of the programme might, in some cases, have unintended negative consequences for sexual self-regulation. In particular, Practitioners speculated that the use of the 'sexual thoughts' diary as part of the HSF module with men whose offence was committed a long time ago could potentially increase their level of sexual preoccupation. Participant interviews also revealed some concerns about completing this diary, particularly in custodial settings – one participant felt he had been left with the diary for too long a period before being able to discuss it with Practitioners, and was also concerned about the diary being read by Prison Officers and "*misinterpreted*".

There was also less discussion within staff or participant interviews of MF:MC's impact on **motivation** to change – discussion around this issue tended to focus on men's motivation as a factor influencing the impact of the programme, rather than something the programme influences. However, both staff and participants discussed the fact that the programme gives men 'goals' to aim towards, which can in turn help bolster their motivation to change.

> *Having goals, it's not something I had really considered at that point. (…) I think the group in the way the programme is set up is just to try and encourage you to have a goal, and take steps towards it and the goals, well hopefully, setting these goals will hopefully stop you offending or reoffending in the future.*
>
> (MF:MC Participant 10)

4.5.6 Wider impacts

In addition to impacts on specific treatment outcomes, participants also discussed the perceived impact of MF:MC on:

- **Self-esteem** – Perceived positive impacts on self-esteem ranged from helping participants to feel more confident, to reducing self-harm and suicidal thoughts.

- **Insight into offending** - The way in which MF:MC helps participants link their past experiences and thoughts with their offending behaviour was viewed as particularly useful:

  > *I've kind of been able to link in my mind things that I've been thinking about in my past and things I've done, so it's kind of helped me at this point anyway to link a few things together, giving me some ideas about possibly why I did what I did.*
  >
  > (MF:MC Participant 11)

- **Feelings about the future** – Participants felt MF:MC had helped them to develop plans and ambitions for the future (which were, in many cases, previously lacking), and to feel more optimistic about what the future holds:

  > *There are different possibilities about what I can do in the future; I can find alternatives to the things that are restricted to me, but have a meaningful life at the same time.*
  >
  > (MF:MC Participant 14)

4.6 Perceived influences on impact

Interviews with MF:MC staff and participants also identified the specific features of the programme they felt contributed to the impacts observed above.

4.6.1 Group structure and dynamic

MF:MC participants and staff expressed very similar views on the scope for group work to support change via:

- **Enabling participants to learn from the experience of others** – for example, understanding how other people came to commit their offence could help with understanding of their own offence. The rolling structure also enabled participants to learn from, and by motivated by, others at different stages of the programme.
- **Peer questioning** – which both participants and staff reported could be more effective than professionals questioning participants. Participants reported that the questions from other group members were sometimes challenging, but that they encouraged them to engage honestly with their behaviours
- **Helping to build confidence, emotional regulation and social skills** by allowing participants to practice talking about challenging topics and listening to others.

  > *They have got different coping strategies and that's how I'm learning all the time in this programme … and I can empathise with the guys because a lot of the guys are in the same boat as me. (…) Some of the questions can be a bit challenging, but I've been told that I don't hold anything back (…) I kept quiet the first couple of sessions until I got my first assignment and that's when I started to come out of my shell.*
  >
  > *(MF:MC Participant 15)*

4.6.2 The overall theoretical approach

Treatment Managers and Practitioners felt that the Good Lives Model meant MF:MC was more engaging, holistic and future-oriented than previous interventions, while the flexibility of the programme and the fact it can be tailored to individual needs was mentioned by both professionals and participants as a positive feature.

Professionals and participants both contrasted MF:MC favourably with previous sex offender interventions, particularly CSOGP (Community Sex Offender Groupwork Programme), which was viewed as both unhelpfully confessional and offence-focused and too strictly structured (it was based on fixed rather than rolling groups), meaning men lost interest. A Case Manager reported that CSOGP had felt like "*punishment*" – in focusing on the future and tailoring delivery MF:MC was "*everything that CSOGP wasn't*."

However, a number of interviewees (including the small number of Police Scotland Stakeholders and MF:MC Treatment Managers) suggested that MF:MC could be a bit "*fluffy*" in comparison with other programmes, and that some men would benefit from more direct challenge about their behaviour. This view was closely linked with debate about whether the programme should address the offence itself more directly, discussed in Chapter 2.

4.6.3 Specific topics and modules

Staff and participants both expressed mixed views on whether any modules were particularly more or less effective. One view was that all topics were equally helpful, although as discussed in Chapter 2 staff expressed concerns about the level of depth in the programme manual guidance and supporting materials associated with some modules. A number of modules and topics were singled out by participants as particularly useful, however.

- **Thinking Styles** – The perception among professionals that some of the content of the Thinking Styles modules was somewhat "*shallow*" did not appear to be reflected in participants' views: a recurrent theme among participants was that work around Thinking Styles was the most challenging element of MF:MC, but also the most beneficial in terms of identifying, challenging and changing unhelpful thinking patterns, and helping participants understand the thinking styles that may have contributed to their offending.

  > *This is what's important for me this bit (Thinking Styles), this is the bit I really want to try and get my head into it and kind of get a comprehensive understanding of why I have ended up where I am today. How my thinking styles linked to my offending. I'm not quite there yet because I'm still trying to un-write the rewritten things in the back of my mind. But, even if I have to spend a bit longer on the programme tackling them, then I'm quite willing to do that, because it will be very beneficial, because then I would be able to unravel it and get a better understanding of it, I can then start to work on how to change it and fix it … have a new thinking style.*
  >
  > (MF:MC Participant 4)

- **Self-management** – Again, although some MF:MC Treatment Managers and Practitioners criticised this module as lacking depth, participants felt that the topic and associated exercises (e.g. the 'problem solving log') had helped them develop better problem solving skills by helping them consider wider options and analyse the possible outcomes.

- **Relationships** – As discussed above, where participants reported improvements in their relationships with friends and family, this was in part attributed to the topics covered in the Relationships module, which had helped them to be more aware of other perspectives and of their own behaviour and its impact on others.

As discussed above, more mixed views were expressed on the **HSF module**. Some participants said this module had helped them understand themselves and their emotions, encouraged different ways of thinking, and helped them open up about sensitive topics. However, others said that although they had found elements of it useful, they were very uncomfortable with aspects of its delivery (such as the sexual thoughts diary and the fact that some sessions were with a female Practitioner which *"didn't sit right"* for one participant). Among MF:MC staff, while the module as a whole was viewed as valuable, it was also criticised for being too limited in the range of topics and techniques included, which were perceived to limit its impact. It was also suggested by Treatment Managers that the HSF module was less likely to impact on paedophilic sexual attitudes, in part because it was perceived to go into insufficient depth for this group of men, and because of challenges around using some of the suggested techniques (such as fantasy replacement) with men with men whose sexual interest are not age appropriate.

4.6.4 Specific approaches

As discussed in the introduction, MF:MC draws on a number of different approaches, including Mindfulness, CBT and Schema therapy. Where specific approaches were discussed by MF:MC staff, this tended to be in the context of debating whether their use as described in the manual is effective for all participants and/or whether there is enough guidance and support for their use, rather than whether or not a particular technique is effective per se.

There was a particular debate around how **Mindfulness** is included in MF:MC. Both participants and staff reported that Mindfulness can be a very useful technique in helping men to self-manage – men described using it to manage depression and anxiety, or to identify and focus on more positive emotions. However, both also reported that some men found it frustrating to have a mindfulness exercise at the start of every group – for men who did not find it useful, this could become a barrier to engagement. It was suggested it should be used more flexibly – for example, towards the end of a session that has been particularly emotionally charged.

4.6.5 External factors

In addition to discussing the ways in which different features of MF:MC design and delivery did or did not contribute to programme outcomes, participants and professionals also discussed a number of factors external to the programme. In particular, the wider social context participants find themselves in could be both a barrier and a facilitator to change. For example, a participant who had found a volunteer role reported that this had given him confidence and helped him to feel trusted again. In contrast, other participants felt that while MF:MC had expanded their horizons, they were limited in the opportunities they had to put their learning into practice by restrictions on who they can have contact with or (for those in custody) a general lack of opportunity to try new things.

I think it should be in tandem with other things. Like you've learnt all this and it's helped you be a better person and all that, but for me it's like, aye, but you've done that work, you've learnt all this stuff, but what are you going to do with it?

(MF:MC Participant 2)

4.7 Meeting diverse presenting needs?

Overall, Treatment Managers and Practitioners indicated that MF:MC is able to address a range of needs and work effectively with a range of offender types. The ability to choose which modules each participant takes and the flexibility to adapt discussion to individual needs were considered key in this respect. However, although staff felt the programme could work for a range of men, they also identified a number of specific groups whose needs they felt were not fully met by the programme at present including:

- **Men with Personality Disorder and/or emotional difficulties** – it was suggested that some of these men have been on several sex offender programmes with no sign of progress and are ultimately not suited to group programmes.
- **Men with early maladaptive schemas**[15] – a psychologist who supported Community MF:MC teams suggested that MF:MC Practitioners are not always equipped to respond to this particular issue. In their view, these men ought to have access to specialist treatment, but this was not always readily available.
- **Men with Autistic Spectrum Disorder** – whose needs were perceived to be more difficult to meet in a group setting.
- **Internet offenders** – as discussed in Chapter 3, there was a debate about the process for identifying the "right" internet offenders to benefit from MF:MC and the risk of 'over-treating' some men in this group.
- **Paedophiles who view their sexual pre-occupation with children as an acceptable orientation** - is was suggested that the manual is particularly limited with respect to addressing the attitudes of this group. One view (expressed by a Case Manager) was that this group of men need external controls and "*no arena for debate"* and should be excluded from group programmes.
- **Men who commit sexual offences in a relationship** – as discussed above, a Case Manager reported that they sometimes referred these men to the Caledonian Domestic Abuse programme rather than MF:MC, on the basis that it was more effective in addressing the specific attitudes they associated with this kind of offence.
- **Men who have already completed multiple interventions** – while staff felt there might be good reasons for repeating sex offender programmes where treatment needs have not been fully met, they questioned the appropriateness of allowing men to attend multiple treatment programmes with no observable impact. It was suggested that issues around potential 'over-treatment' were more directly addressed within CSOGP.

Another view was that while diverse needs can be met by MF:MC, attempting to meet very diverse needs in the same group may limit its effectiveness for individual group members – for example, including men with lower cognitive abilities and those with high IQs in the

[15] Defined in Schema Therapy as "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree." http://www.schematherapy.com/id63.htm

same group can lead to frustration among the latter that the group is not operating at a sufficiently high level.

Discussion around the effectiveness of MF:MC for these diverse groups touches on issues already raised around:

- the assessment process and whether it effectively assesses programme suitability (particularly with respect to internet offenders and "deniers")
- the content of the manuals and whether the topics and techniques are sufficient to enable effective delivery to diverse participants
- the training and support staff receive to develop the skills needed to address very diverse needs, and
- the external resources available to support delivery.

With respect to this latter point, MF:MC staff and stakeholders argued that it is not reasonable to expect every MF:MC Practitioner to develop expertise in every delivery technique that may be needed to meet every set of presenting needs likely to be encountered within MF:MC. It was felt that this was not sufficiently recognised within the programme at present – the manuals were seen as assuming staff would simply supplement materials with their own expertise to ensure the programme could meet identified needs. This issue is discussed further in the next section (suggestions for improvement).

4.8 Suggestions for improvement

4.8.1 Potential improvements to enhance impact

Chapters 2 and 3 have already outlined various suggested improvements to the delivery of MF:MC and to the assessment process that are ultimately aimed at enhancing its impact. Additional recommendations stemming from the discussion in this chapter relate primarily to the challenges of meeting extremely diverse needs. Suggestions (primarily from Treatment Managers) include:

- **Provide more external expertise to support delivery** – in addition to reviewing the availability of external psychological support for community sites, discussed in Chapter 2, it was suggested that given the scope of MF:MC there was a need to engage experts in specific areas (such as internet offenders, working with people with offenders with learning disabilities, working with paedophiles who view their sexual pre-occupation with children as an acceptable orientation, etc.) and approaches (e.g. Schema Therapy, sex therapy) to review current content and practice (which could include, for example, reviewing guidance on whether/when/how the 'sexual thoughts' diary should be completed), and to help upskill staff. A participant who had learning disabilities suggested that while MF:MC staff were very "*patient*" with him, he felt they ought to involve someone with expertise in learning disabilities (similar to a Special Educational Needs teacher in school), who could both help him progress faster and advise staff on how to make the content more accessible to him.
- **Assign national leads on specific approaches and issues** – as an alternative or addition to involving external experts on a regular basis, it was suggested that there should be national leads on specific approaches and issues within MF:MC, with a remit to keep up to date on best practice and research and to ensure the programme reflects this. Given the resourcing issues identified in Chapter 2, this would almost certainly require additional staff resources.

- **Consider the impact of/guidance on 'over-treatment'**, where men have attended several group interventions without apparent progress. Alongside this, it was suggested that options for supplementary treatment and/or structured alternatives to MF:MC should be considered for those who may not be well-suited to group-based programmes (e.g. men with ASD, some men with Personality Disorders).
- **Consider the feasibility of establishing separate groups for men with lower cognitive functioning** – while this may not be feasible across all community sites, it was suggested it ought to be possible to establish such a group within SPS.

4.8.2 Potential improvements to impact measurement

The first part of this chapter identified substantial perceived limitations to the data currently collected within MF:MC which could be used to assess impact. Overall, there is a **need to systematically review what outcome measures are being collected** to:

- Ensure they include valid and reliable measures of all intermediate treatment targets
- Improve practitioner trust, understanding and use of these measures, so that they are more likely to be collected and entered systematically and on time, and practitioners are able to use them to inform both individual treatment and their own understanding of how the programme is working locally.

Specific issues this review of outcomes should consider include include:

- **The utility of the psychometrics included in the programme** – given concerns raised by MF:MC teams, and wider academic debate about the utility of psychometrics, the utility and appropriateness of the current battery for use in measuring treatment outcomes with sex offenders needs to be formally reviewed. Are they the best measures available for the treatment outcomes MF:MC is attempting to effect? If any of the existing scales are to be retained, or if they are replaced with alternative measures, there will also be a need to provide clearer evidence to support their inclusion and clearer guidance to support their interpretation at individual, site and programme level. This should include providing clear guidance on:
    - When a particular score indicates a clinical issue?
    - What would be a significant pre to post-programme shift (at individual level)
    - What normative data (from appropriate comparative groups for the population) should scores be compared against?
- **Whether additional measures of success are needed**, linked to specific treatment needs. Although Stable 2007 is closely aligned with treatment objectives, it was suggested that this could be supplemented with, for example, scales rating the level of insight participants are believed to display alongside evidence of specific behaviours linked to each outcome.
- **Ways of reducing the reliance on self-report data to measure outcomes**. Treatment Managers in custodial settings suggested that there are various more objective measures of deviant sexual interest/sexual pre-occupation that could be incorporated, for example. Suggestions included using software developed to measure view time of images, in order to identify deviant sexual interests pre and post-programme.

- **The wording of the significant others' questionnaire, and clarifying who should (and does) complete it**. The current wording of this questionnaire makes interpreting the findings difficult – in particular, it is unclear what 'no change' means, since we do not know if the respondent considered this to be a problem area in the first place. There is also a need to clarify who is able to complete this, and to record who actually completes this (i.e. their relationship to the respondent), to enable accurate analysis and interpretation of this data. Finally, the value of both the significant other and participant exit questionnaires would be enhanced if the questions were more closely aligned – enabling both practitioners and evaluators to compare men's views of their progress with the assessments of their significant others more directly.

5. Conclusions

This concluding chapter revisits the three primary research questions for this evaluation, and reflects on the key findings with respect to each. It ends with a brief discussion of the wider debate around 'what works' with sex offenders, in order to inform future discussions about the development of MF:MC.

5.1 Is programme integrity maintained?

Manualised programmes are intended to ensure that interventions are delivered consistently across sites and that the integrity of programme design is retained. As discussed in the introduction, MF:MC is supported by a set of manuals, outlining how the programme is intended to operate in terms of: its broad theoretical approach; practicalities, such as frequency of delivery, management and resourcing; content; and evaluation and assessment.

Overall, the evaluation indicates that MF:MC is being delivered with fidelity to the Good Lives Model – that sessions are focused on helping participants re-evaluate their life goals and develop skills to achieve those goals without harming others. It also appears to be being delivered in an engaging and responsive manner, with staff tailoring both the optional modules and more specific content where necessary to address individual needs.

In terms of the practicalities of delivery, while the programme is being delivered on a group basis, in 2-3 hour long sessions, by staff who have received mandatory MF:MC training, most of the community sites were diverging from the frequency of sessions recommended in the manual, running sessions once a week rather than twice. The main reason given for this was staff resourcing, which was also perceived to be impacting to different degrees on the teams' abilities to provide consistent supervision at the frequency recommended in the manual, and to engage in CPD to support delivery. Specific challenges around access to dedicated psychological input to support delivery in community sites means it is unclear whether or not the HSF module is being delivered as intended by the programme designers.

Assessing whether or not programme integrity is being maintained with respect to content is complicated by the fact that a degree of flexibility and responsivity is built into MF:MC. In practice, sites reported spending considerable time identifying their own materials to supplement the manual and support delivery, creating inevitable variations in the precise content being delivered. There was a particular debate about the acceptability or desirability of discussing the offence within MF:MC, which may require further consideration. While some sites actively avoided discussing the offence and saw this as a strength of the programme, others felt it created "an elephant in the room" and had incorporated material from other programmes around this.

The referral and assessment process appears largely to be followed as outlined in the manual, and is largely successful in identifying men who are 'medium' or 'high risk' as rated by Stable 2007 (only 2% of entrants were 'low risk'). However, some concerns were raised about whether the current process is always identifying those most *suitable* (as distinct from eligible) for the programme, particularly with respect to internet offenders and men who deny their offence. In terms of evaluation, as discussed below, there appear to be a number of ongoing issues with the MF:MC IT system which are limiting the usefulness of the data it contains, both for evaluation purposes and for informing and supporting programme delivery.

5.2 What are the main outcome measures and to what extent have outcomes been realised?

Ultimately, MF:MC aims to reduce reoffending. However, as a programme based in the Good Lives Model, it aims to do so by helping men who have committed sexual offences to develop life goals and the skills they need to achieve these in a pro-social manner. More specifically, it aims to address a number of issues identified as 'Stable Dynamic' risk factors for re-offending (which are also factors that influence the ability to live a 'good life'), including: significant social interests; intimacy deficits; general self-regulation; sexual self-regulation; and co-operation with supervision. In addition, it aims to identify problematic attitudes, motivation to change, and victim empathy, which are all viewed as potential risk factors (although there is doubt in the research literature about the significance of victim empathy in this respect).

Examining recidivism among sexual offenders is very challenging – as Przybylski (2014) notes, "The surreptitious nature of sex crimes, the fact that few sexual offenses are reported to authorities, and variation in the ways researchers calculate recidivism rates all contribute to the problem". Rates of reoffending also tend to be lower for sexual crimes than for other kinds of crime, to differ across different types of sexual offender, and to take a relatively long period of time to occur (Przybylski finds estimates ranging from 5% after 3 years to 24% after 15 years). MF:MC has only been in operation in Scotland since 2014. Even without the challenges noted above, this is an insufficient timescale for any impact on reoffending rates to be observable. As such, Chapter 4 of this report focuses on evidence of potential impact on the risk factors the programme aims to influence, rather than on reoffending itself.

As discussed, there are some significant limitations to the data available to measure impact on these risk factors. In particular, the lack of a control group means it is not possible to attribute any observed changes conclusively to MF:MC, while as discussed below there is room for improvement to the outcome measures included in the programme monitoring data. However, the data that is available is generally quite positive in terms of the perceived impact of MF:MC. Overall, level of risk as scored by Stable 2007 decreases for a majority of men over the course of the programme, while a significant proportion of men also see positive changes in scores measuring psychological traits potentially associated with risk of reoffending. Men expressed positive views about the programme's impact, both within the exit survey and in the qualitative interviews conducted for this evaluation. And staff and Case Managers reported that feedback from others and their own observations indicated it was having a positive impact across a range of risk factors.

Comments from staff and men indicate that the Good Lives approach was viewed as having a "*better chance*" of engaging men and having an impact than previous programmes, which focused more exclusively on risk and on the offence itself. The views of the three police stakeholders interviewed for this evaluation, however, struck a more sceptical note, and reinforce the need to reconsider what data is collected on outcomes going forward (discussed below).

5.3 Are there difficulties with delivering any aspects of the programme and improvements that could be made?

The final section of each of the previous chapters has included detailed suggestions for improvement to MF:MC. Rather than simply repeat these, this final section reflects on three over-arching areas the evaluation suggests may need further consideration and

refinement in order to maximise the potential impact – and to assess this more effectively – going forward.

5.3.1 Programme scope and resourcing

Chapter 2 in particular identified a number of areas for improvement relating to programme resourcing. Ultimately, the resourcing requirements – in terms of staffing, training, expert input, and materials provided – depend on exactly what the programme is trying to deliver. If MF:MC is intended to be suitable for most medium-high risk sex offenders in Scotland, regardless of nature of offence, whether they deny their offence, their psychological profile or cognitive capacity, then the implications of this need to be considered for:

- **The expertise required to deliver MF:MC** – for example, what psychological approaches teams need to be trained in; what level and type of ongoing psychologist input is required in community settings; and what expert input might be required to ensure the programme is (and stays) at the cutting edge of understanding around treating a wide range of presenting needs.
- **The overall level of resourcing** – in the light of increasing numbers of RSOs in Scotland, the level of resourcing required to deliver MF:MC needs to be kept under continual review, particularly if there is an aspiration for community sites to deliver sessions twice a week.
- **Additions/alternatives to MF:MC groups** – comments about groups of men whose needs are not currently perceived to be fully met by MF:MC raise questions about whether there is a need to supplement MF:MC with alternative or additional input for these groups. While it may be possible to meet some presenting needs in a slightly different group programme (such as the specific programme for men with low cognitive function, discussed in Chapter 2, or within the Caledonian System for men who commit sexual offences within relationships), comments by staff and Case Managers suggest that some men (e.g. those with personality disorder, or with Autism) might require both alternative content and delivery (e.g. 1-1 or 2-1) to more fully meet their presenting needs.

5.3.2 Programme manuals

Discussion with Treatment Managers and Practitioners identified a number of areas where the Programme Manual in particular appears to require further development to ensure that it provides sufficient depth to meet diverse presenting needs. The Thinking Styles and Self-Management modules were particularly singled out in this respect. There is also a need to consider strengthening the supporting materials provided to enable staff to deliver MF:MC in an engaging manner, both to reduce the burden on staff who are currently spending time identifying their own materials, and to reduce the potential for unintended variations between sites. This might be supported by the development of an MF:MC Knowledge Hub, where additional materials can be accessed and shared.

At the same time, interviews with MF:MC staff identified an overarching issues around what level of deviation from the manuals is actually acceptable. This requires clarification in general, and in particular with respect to discussing the offence - how far (if at all) is it acceptable to go with introducing additional material around this?

5.3.3 Monitoring and evaluation

This report has identified a number of issues around the monitoring data collected for MF:MC. In order to improve the validity, quality and relevance of the data going forward, there is a need to review:

- **What is collected** – to ensure that all data items (including all psychometric scales) are clearly mapped to intended programme outcomes and that all measures are valid and robust. This should include considering whether there are any more objective measures that could be incorporated, for example around the presence of deviant sexual attitudes.
- **When and how it is collected (and how data input is monitored within and across sites)** – to minimise inconsistencies between sites where possible in terms of, for example: the stage at which pre-programme Stable 2007 assessments are conducted; how psychometric tests are introduced and supervised; and who completes the significant other questionnaire.
- **How to increase the usefulness of the data collected in ongoing monitoring and evaluation** – in order to support the delivery and development of the programme by staff and, as a consequence, make it more likely that data collection will be prioritised (and will therefore be complete and accurate).
- **Whether/how longer-term outcomes can be monitored** – at present, the data collected only relates to short-term changes in men's reported attitudes and behaviours, immediately following completion of MF:MC. Consideration should be given to the scope for incorporating longer-term follow-up of MF:MC participants – for example, revisiting Stable 2007 and/or other measures with men in the years after completion of MF:MC (Dennis et al, 2012, suggest that offenders should be followed-up for a minimum of five years in the community).
- **Whether/how a control group can be established for MF:MC** – a recent systematic review of research on sex offender interventions came to the "inescapable conclusion" that there was a need for further randomised controlled trials (Dennis et al, 2012). Conducting such trials is costly and challenging. However, given the impossibility of concluding that any observed positive impacts from MF:MC are the result of the intervention itself, and the fact that recent evaluations of other sex offender interventions have found either inconclusive or negative evidence for any impact on reoffending, there is a clear argument for assessing the feasibility of a longer-term experimental or quasi-experimental evaluation of MF:MC.

5.4 MF:MC and 'what works'?

A detailed summary of the international literature on 'what works' in interventions with sex offenders generally, or an assessment or the extent to which MF:MC conforms to current thinking on 'best practice' (in itself a contested issue) is beyond the scope of this evaluation. However, some brief reflections on emerging evidence and key debates may be useful in informing future discussions about the development of MF:MC. First, it is important to note that internationally, the quantity and quality of evidence in this area has repeatedly been judged to be limited (for example, a 2012 Cochrane review concluded that there were "far fewer than the number [of studies] that would give one any confidence in the findings" – Dennis et al, 2012). Cognitive behavioural approaches have been most frequently evaluated. The evidence is not always conclusive – some recent systematic reviews have found no difference in outcomes between sex offenders who participated in CBT-based or other behavioural programmes and those who did not (e.g. Dennis et al, 2012, Langstrom et al, 2013). However, Kemshall (2013) reports that overall there is evidence of a positive impact from CBT-based approaches. Similarly, Schmucker and Losel's meta-analysis (2015) found a small but significant impact on recidivism rates, and report that Cognitive Behavioural and multi-systemic treatment revealed better effects. Kemshall also reports some support for the Good Lives Model (e.g. Hanson and Yates,

2013) as an example of more positive, future-oriented approaches which are strongly supported in the wider desistance literature (though to date there have been few robust outcome evaluations of GLM-based interventions with sex offenders).

In her review of the evidence, Mann (2014) argues that "a constant theme from the systematic reviews is that we need to get our treatment content more firmly fixed on what we know to be criminogenic needs for sexual offences". The treatment targets she identifies as having a strong link with reconviction closely mirror those included in MF:MC:

- Sexual preoccupation and deviant sexual interests
- Offences supportive attitudes and hostile schemas
- Relationships – lack of intimacy with adults, emotional congruence with children
- Self-regulation – impulsivity, poor problem solving, non-compliance with rules.

Conversely, Mann notes that evidence indicates that 'taking responsibility for offending' appears not to be related to reoffending, which supports the potential for including deniers on such programmes, as in MF:MC. Victim empathy is also not shown to be associated with reoffending, although as discussed earlier, this has been included in MF:MC on the basis of it "being an appropriate way to achieve attitude change" (MF:MC Theory Manual, 2014: 65).

While there is an emergent consensus on the intermediate outcomes which programmes should target to reduce sexual offending, the most appropriate treatment structures and precise techniques for effecting change in each of these areas remains the subject of considerable debate, however. For example, while many sex offender interventions are based around group work, various authors have highlighted the need for care to avoid unintended negative effects, such as 'deviance modelling' by higher risk offenders to lower risk offenders (e.g. van der Put et al, 2013). While this would support MF:MC's exclusion of low risk offenders, the recent evaluation of the prison-based Core Sex Offender Treatment Programme in England and Wales (Mews et al, 2017) has stimulated further debate about group-work programmes. The evaluation authors, who found that recidivism was higher among those who had participated in the programme than in a matched comparison group, argue that treatment approaches may need to include more individual, as well as group, sessions. However, they also acknowledge that "The study does not reveal the extent to which Core SOTP reoffending outcomes are due to treatment design or poor implementation", highlighting again the contested nature of evidence in this area.

In terms of the efficacy of specific techniques, again the evidence is often tentative at best. Although cognitive behavioural methods are generally regarded as effective, Kemshall notes that not enough is known about "exactly what works, how and for whom" (2014: 6). Mann's 2014 summary of the evidence indicates that:

- Cognitive restructuring therapeutic approaches can be effective in addressing attitudinal risk factors (but the approach can often be misapplied or misunderstood as focusing on 'taking responsibility for the offence')
- Schema therapy may be useful, for example in reducing grievance thinking, entitlement and suspiciousness, though the research is limited
- Empathy training (rather than 'victim empathy') can change attitudes, and
- Mindfulness may have an impact on emotional regulation (though evidence is early).

In summary, the research base on sex offender interventions is still developing – definitive conclusions about ‘what works’ are difficult. If interventions like MF:MC are to remain ‘evidence informed’, this will require ongoing engagement with emerging evidence on good practice.

References

Davies, H (2013) *Civil Prevention Orders: Review,* London: ACPOS

Dennis, JA, Khan, O, Ferriter, M, Huband, N, Powney, MJ, Duggan, C (2012) *Psychological interventions for adults who have sexually offended or are at risk of offending (Review)*, Cochrane Library

Ffyfe, M (2015) 'Risked to death: a study into practitioner perception of the implications of Scotland's sex offender management system on the rehabilitation of registered sex offenders', in *Internet Journal of Criminology*

Hanson, RK and Yates, P (2013) Psychological treatment of sex offenders, *Current Psychiatry report 15*, issue 348

Kemshall, H, Kelly, G, Wilkinson, B, Hilder, S (2014) *Literature review: What Works in work with Sexual offenders*, SOMEC

Langstrom, N, Enebrink, P, Lauren, E-M, Lindblom, J, Werko, S, Hanson, RK (2013) 'Preventing sexual abusers of children from reoffending: systematic review of medical and psychological interventions' in *The BMJ*

Lloyd, CD, Hanby, LJ, Serin, RC (2014) 'Rehabilitation group coparticipants' risk levels are associated with offenders' treatment performance, treatment change and recidivism', in *Journal of Consulting and Clinical Psychology*, 82:2, 298-311

Lovins, B, Lowenkamf, C and Latessa, E (2009) Applying the risk principle to sex offenders: can treatment make some offenders worse? *The Prison Journal*, 89:344

Mann, R (2014) *Presentation*: *Defining and developing good evidence for policy and practice*, NOMS, presentation available at: http://www1.uwe.ac.uk/hls/research/offenderengagement/visitingscholarships/evidencebasedpolicy.aspx

Mews, A, Di Bella, L and Purver, M (2017) *Impact evaluation of the prison-based Core Sex Offender Treatment Programme*, Ministry of Justice

Przybylski, R 'Chapter 5: Adult sex offender recidivism' in US Department of Justice (2014) Sex offender *management assessment and planning initiative*, available at: https://www.smart.gov/SOMAPI/pdfs/SOMAPI_Full%20Report.pdf

RMA (2013) *The Evaluation of the Implementation of Stable and Acute 2007 in Scotland*, Risk Management Authority

RMA (2016a) *An evaluation of the Moving Forward: Making Changes training programme in the community: end of study report*, Risk Management Authority

Russell, K and Darjee, R (2013) 'Practical assessment and management of risk in sexual offenders' *Advances in Psychiatric Treatment, 19 (1) 56-66*

Schmucker, M and Losel, F (2015) 'The effects of sexual offender treatment on recidivism: an international meta-analysis of sound quality evaluations' in *Journal of Experimental Criminology*, 11:4

Scottish Government (2014) *Multi-Agency Public Protection Arrangements (MAPPA) in Scotland National Overview Report 2013/14*, available at: http://www.gov.scot/Resource/0046/00462072.pdf

Scottish Government (2017a) *Multi-Agency Public Protection Arrangements (MAPPA) in Scotland, National Overview Report 2016/17*, available at: http://www.gov.scot/Resource/0052/00526596.pdf

Scottish Government (2017b) *Recorded Crime in Scotland 2016/17*, available at: http://www.gov.scot/Resource/0052/00525055.pdf

Van der Put, CE, Asscher, JJ, Stams, GJ, van der Laan, PH, Breuk, R, Jongman, E and Doreleijers, T (2013) 'Recidivism after treatment in a forensic youth psychiatric setting: the effect of treatment characteristics' in International Journal of Offender Therapy and Comparative Criminology, 57, 1120-1139

Moving Forward: Making Changes manuals

Theory Manual, version 1.3

Management Manual, version 1.1

Programme Manual, version 1.4

Assessment and Evaluation manual, version 1.5

Annex A – Topic guides

Treatment Managers topic guide

Pre-interview

Review any emails / previous correspondence with treatment managers and make notes on specific areas to follow-up on/seek more detail about in this interview.

Introduction

- Thanks for taking part
- Introduce self, Ipsos MORI and the evaluation (on behalf of Scottish Government, feeding into application to reaccreditation by SAPOR, interviewing men, staff and key professionals, reporting in January 2018)
- Duration of interview (approx. 1 hour)
- Topics we want to discuss
- Confidentiality – won't use any names in reports or refer to location if quote professionals directly
- Recording – for Ipsos MORI use only, will be securely stored and deleted after project. Check consent to record?
- Any questions?

Roles

I'd like to start by finding out a bit more about your role within the Moving Forward: Making Changes programme and how it fits into any other roles you may have.

- What does their role on MFMC involve?
    - Are they involved in delivery as well as management? (NB managers are supposed to be involved in delivery 1 out of every 6 sessions)
    - Are they involved in overseeing the monitoring data? In what way?
    - How long working on MFMC? Involved in any previous sex offender programmes?
- *NEXT QUESTIONS, REFER TO NOTES FROM EMAIL/INCEPTION REPORT AND CLARIFY IF NECESSARY*
    - Is MFMC their only role or other roles too? If yes, what? IF OTHER ROLES – what % of time is on MFMC?
    - Who else is involved in delivering MFMC in their area/prison? How many people in what roles?
    - Are rest of team working solely on MFMC or do they also have other roles?

Management and delivery of MFMC in their area

Before I ask you about your views on specific aspects of the programme, I'd like to find out a bit more about how MFMC is managed and delivered in your area/prison in general. *(REFER TO EARLIER EMAILS ON ANY DIFFERENCES, AND FOLLOW-UP / PROBE ON OTHER AREAS AS APPROPRIATE).*

- As far as you are aware, are there any elements of MFMC that you manage or deliver differently from the manuals?
    - Why is that?
    - How is this done?
    - What are the pros and cons of doing things differently?
- What are the main challenges to delivering MFMC as it is set out in the manuals?
- How, if at all, could the MFMC manuals be improved?
- What are the benefits and limits to how MFMC is delivered in your area?
    - Are their aspects where deviate from manual/other areas that work particularly well?
    - Are there aspects of delivery they would ideally do differently? If so, why not?
- As far as you are aware, are there any differences between how the programme is managed or delivered in this area/prison compared with how it is delivered elsewhere? PROBE for differences in:
    - How delivery team is structured/roles?
    - Resources available?
    - Assessment processes?
    - How programme itself is delivered? (e.g. group vs. 2-1)
- Views on the reasons for these differences? Resources? Local structures? Tailoring to improve for local needs?
- And views on the pros and cons of these differences – esp. for programme effectiveness

Resourcing of MFMC

Do you feel you have sufficient resources to be able to run the MFMC programme as it is designed in your area/site? If not, what else is needed?

- Staff resources?
- Other resources – e.g. do they have access to all the resources listed in manual (p33): accommodation; recording equipment; learning aids; participant materials; storage facilities?
- Able to operate within budget?
- Have they encountered any unexpected resource issues or unforeseen costs since starting the programme?

Thinking about staffing specifically, do you feel you have sufficient trained practitioners to be able to deliver the programme effectively?

- Do all staff have enough time to do their jobs effectively? If not, why not?
- Have all staff received adequate support and training, at the right time, from the programme? (*NB MANUAL STATES THAT STAFF SHOULD START DELIVERING WITHIN 3 MONTHS OF MFMC TRAINING)*
- Staff recruitment – any challenges recruiting appropriate new staff?
- What about resources available for supporting and developing staff in their roles? Are there any challenges around providing appropriate support and development to your teams? (REFER TO EMAIL RE. WHAT SUPPORT IS PROVIDED, INCLUDING BOTH COUNSELLING/DEBRIEFS AND COMPETENCY CHECKS)

Partnership working

Who are the main partner agencies that you work with on MFMC in your area/prison?

- How effective do you feel partnership working is on MFMC? Are there specific partners where partnership working is more/less effective?
- What areas of interagency working could be improved? How?
- IF NOT MENTIONED BY COMMUNITY TREATMENT MANAGERS – probe around partnership working with psychiatry/psychology – do they feel they have enough support/input from psychology/psychiatry? If not, where would they like more support? *(REFER TO EMAILS)*

Process of assessing men for MFMC

REFER TO RESPONSES TO EMAILS RE. WHO CARRIES OUT ASSESSMENTS ETC.

How well do you think the process for assessing men for suitability for MFMC works in your area? Why? How could it be improved?

- FOLLOW UP IF NECESSARY ON ANY ISSUES RE:
    - Who carries out assessment
    - Timing of assessment
    - Content of assessment.
- Is the programme reaching its intended target group? If not, who is over or under-represented, and why?

Psychometric assessments

REFER TO EMAIL RESPONSES AND FOLLOW-UP/PROBE

Do all men on the course complete the assessment battery before and after they start the group sessions? If not, why not?

- Any issues / challenges getting these completed (in general / for specific men – e.g. those with learning difficulties)? How do they deal with these issues?
- How useful are the assessments? Are they effective at helping understand men's motivations and needs? Do they inform how they work with individual men?

Transitions between prison and community programme

Have they had many men transferring between prison and community programme in their area/prison?

- How well does this process work?
- What, if anything, could change to improve this?

Engagement with the programme in their area/prison

How common is it for men in your area/prison who are offered MFMC to refuse it altogether? Why do you think this is?

- Are there particular groups of men more or less likely to refuse treatment?

Once men have been assessed as suitable and agreed to take part, in general, how high are the attendance rates on the programme?

- Are there particular groups of men more or less likely to engage with the programme once referred? Why? Probe on individual reasons vs system reasons – i.e. anything about how the programme is delivered that contributes to disengagement?
- Are there particular points / particular modules where men tend to disengage/drop out? Why?
- How do you deal with unwilling participants, who start to withdraw or who skip sessions?

Managing group sessions

How do you allocate men to the different groups/2-1 pairs?

- Are there enough places on the programme to meet current demand?
- How easy or difficult is it to assign a suitable mix of individuals to a group/pairing (in terms of culture, race, age, developmental/cognitive factors, offence type etc)? Have they experienced any challenges re. group mix? How did they address these?
- How easy/difficult is it to fit participants into the different modules (both compulsory and optional)?

- Do they have any men who are also on other programmes – e.g. Caledonian? How does MFMC fit with other interventions? Any challenges / things that could be improved on this front?

How are sessions delivered? (*key question)
REFER TO EMAILS AND FOLLOW UP WHERE NECESSARY

- How often do groups/2-1s run? How long do they last? Any challenges re. timing/frequency of sessions?
- Are sessions very structured, or fairly flexible? Do you tailor your approach depending on the particular group? In what way?
- Are any of the modules more/less effective?
- Any approaches you find more/less effective than others? With particular types of men?
- How is delivery adapted to fit the needs of different offenders? (e.g. rapists vs internet offenders; different learning styles and cognitive abilities)

Ending the programme

- How long do you find men are typically on the programme in your area/prison? Reasons/types of men it takes longer for?
- Do you think the programme is too long/too short?
- After the post-treatment process has been completed how common is it for men to re-enter the programme?
    - Main triggers to relapse?
- How are participants followed up after completing the programme?

Overarching views of MFMC
How effective, overall, do they feel the MFMC programme is?

- How do they assess how effective it is? What evidence do they have of it changing men's attitudes? And their behaviours?
- Is it more or less effective for different types of men? Different types of offence? Different cognitive abilities? Why?
- How does MFMC compare to other reoffending programmes they've been involved in?
    - What are the relative pros and cons / challenges?
- How helpful are the manuals? What aspect are most useful? And least? How could they be improved?

Other changes?

Are there any other areas where they feel the MFMC, or the way it operates locally, could be improved? How? Probe fully.

THANK AND CLOSE. ASK FOR PERMISSION TO EMAIL/RING IF ANY FOLLOW-UP QUERIES.

Participant topic guide

Introductions (5 mins)

- Thanks for taking part
- Introduce self, Ipsos MORI and the evaluation:

  e.g. "Ipsos MORI is doing research about 'Moving Forward: Making Changes' for the Scottish Government. We want to find out what people think about taking part in the programme.

  The aim of the interview is to understand what you think of the programme and how it could be improved.

  Your views and experiences will help the Scottish Government and its partners think about how to improve programmes like Moving Forward Making changes in the future."

- Duration of interview (approx. an hour)
- Topics we want to discuss
  - What you thought when you first heard about the Moving Forward: Making changes (MF:MC) programme
  - What kinds of things you talk about in MF:MC groups/sessions
  - How, if at all, you think taking part in the MF:MC programme has affected you
  - How the programme can be improved.
- If any questions you don't want to answer, or if you want to take a break, that's fine – just let me know
- Confidentiality – won't use any names in reports or share our conversation with anyone outside the research team at Ipsos MORI. Only time we might need to pass on something you say in an interview with anyone else would be if you tell us something that makes us concerned someone is in danger of serious harm.
- Recording – for Ipsos MORI use only, will be securely stored and deleted after project.
- Any questions?
- **Consent sheet** - if happy to take part and be recorded, ask them to sign.

<u>Background information</u> (2 mins)
Purpose: to get a bit of context about the participant to help frame/inform later discussion and find out what stage of MFMC they are at.

- Just to start off with, can you tell me how old you are?

COMMUNITY INTERVIEWS ONLY:

- Are you working or not just now? If yes - what kind of work do you do?

ALL:

- How long have you been attending sessions for MF:MC?
- Is this your first time on the programme or have you re-entered? IF YES: When were you on it before, and when did you re-enter the programme?
- And have you only been on Moving Forward Making Changes in (SITE), or did you move onto the programme here from somewhere else? (TO TRY AND IDENTIFY ANY WHO HAVE TRANSITIONED, ESPECIALLY PRISON-COMMUNITY OR VICE VERSA)
- What stage of the programme are you currently at? E.g. are you attending group/2-1 sessions, or have you finished this stage? Do you still have any contact with MFMC staff or have you completely finished the programme?

<u>Expectations of MF:MC</u> (5 mins)
Purpose: to establish what they thought MF:MC was and what their expectations were at the start (before they actually started participating)
I'd like you to think back to when you started with the Moving Forward Making Changes programme. I'm interested in what you knew about it and how you felt about it at the start.

- When did you first hear about the Moving Forward Making Changes programme? PROBE – how found out about it / who heard about it from?
- What did they tell you about it? When you were first told about it, how did you feel about taking part in the programme? PROBE: Were you mainly positive / negative about it?
    - What, if anything, did you hope or expect the programme might do for you?
    - What, if any, concerns did you have about taking part?

<u>General experience / views of group or 2-1 sessions</u> (15 mins)
***** PRIORITY SECTION *****
Purpose: to establish what kinds of things they do/talk about in group/2-1 sessions, and what think more/less useful.

- Do you take part in MFMC in a group with other men, or in a session with one other man?
- Can you take me through a typical group / meeting (if 2-1)? (types of things they do, talk about, who leads it, who else is there, etc).

  PROBE AS NECESSARY
  - How many people are in the group?
  - How long do the groups/meetings last?
  - Where do they take place?
  - Who leads it? Are there other people involved in running sessions?
  - How often do groups/meetings take place?
  - What sorts of things do you usually talk about in group sessions?
  - What kind of exercises or activities do group workers use? What is your opinion on these?
- What kinds of things have you talked about as part of your MFMC groups/sessions? PROBE FULLY – what else?
- What issues did you find it particularly useful to discuss? PROBE: why? Content vs. how it was delivered/covered?
- What issues or topics did you find less useful? PROBE why?
- Why was this issue / topic useful / not useful for you?
- What are the group sessions like? PROMPT IF NECESSARY: For example, would you describe them as engaging or boring? Difficult or easy? Why?
- What are the people who run the groups like? How would you describe them? What is good/bad about how they run the group?
- What is the relationship between the people in the group like?
  - PROBE: how do you get along? Does everyone get chance to contribute? Are there ever any difficulties around working together? How are these resolved?
  - (*If issues around having group members who deny their offence come up, probe fully around this* – how does that affect the group?)

<u>Case management/other contact with MFMC</u> (5 mins)
Purpose: to establish how relationship with case manager works/feeds into MFMC experience

- Do you have someone you meet with one-to-one as part of MFMC too?
    - Who is that?
    - How often do you meet with them at the moment?
    - What kinds of things do you talk to them about?
- How do you find the meetings you have with your case manager/worker? PROMPT IF NECESSARY: Useful/not useful? Challenging? Supportive? Difficult? Why?
        - Is there anything about how they work with you that you would change?

<u>Level of engagement with MFMC</u> (5 mins)
Purpose: to establish how engaged they've been across the programme and what if anything explains any lower engagement.
(If any points where felt / were less engaged, try and establish when this occurred)

Thinking about everything you have done on the programme since you started …

- Was there any point when you felt less happy about taking part? When? For how long? Why felt that way?
- Was there any stage that you stopped coming to groups or meetings for a while? When? For how long? Roughly how many did they miss?
- Why? What, if anything, encouraged them to come back? At that time was there anything that could have helped to encourage you to come to meetings, or feel more positive about coming to them?

<u>Experience of transition/re-entering the programme (5 minutes) (THOSE WHO HAVE TRANSITIONED/RE-ENTERED ONLY)</u>

- THOSE WHO HAVE TRANSITIONED BETWEEN SITES: Earlier, you mentioned that you'd moved onto the programme here from somewhere else. Can you tell me a little bit more about how moving between different places delivering Moving Forward Making Changes worked for you?
    - Did you experience any issues around moving between sites? What? How did this affect you / your experience of the programme?

- THOSE WHO HAVE RE-ENTERED THE PROGRAMME: You mentioned earlier that you had taken part in MFMC before this time. How was it coming back onto the programme?
    - How did it compare with experience first time round?
    - How did you feel about repeating elements?

<u>Impact of the MF:MC programme</u> (10 mins)

Purpose: to establish what, if any, impact they feel the programme had on them across range of areas it tries to influence.
KEY SECTION *– should take most time.*

ASK OPEN QUESTIONS FIRST AND PROBE AS FULLY AS POSSIBLE.

- How, if at all, do you feel your life has changed since being on the Moving Forward: Making Changes programme?
- ***<u>If changed</u>*** – in what ways? Probe fully for both positives and negatives. What, if any, changes have you noticed to:
    - how you **see the world**
    - how you **behave**
    - your **you manage your emotions**
    - your **relationships with other people**
    - how you **plan for the future**?
- What do you think contributed most to this change? PROBE FULLY – MF:MC vs other things?
    - *If MF:MC*, which elements? Staff delivery (which staff – case manager or group workers?)? Programme content? Etc. If necessary, prompt – being in a group, 1-1 sessions, any particular topic you discussed?
    - *If other things*, what were they e.g. family/friends, their own self-motivation, other services?
- Are there any other areas where you would have liked to achieve things or change, where you don't feel there has been as much change? IF YES, PROBE AS BELOW, FOR 'NO CHANGES'.
- ***<u>If no changes</u>*** – how do you feel about that? Are there areas where you would have liked thing to change? What has got in the way of changing these? What, if anything, could the MF:MC have done that might have made a difference/ helped change these things?

Overview of impact and suggestions for improvement (5-10 minutes)

- Overall, do you think the programme has helped you? In what way in particular? And what part of the programme has helped you most? And what has helped you the least?
- Have there been any negatives from taking part? Probe fully. What might have helped prevent this from happening?
    - Are there parts of the programme that haven't worked as well for you as others? Probe around content, delivery, 1-1 vs group sessions, etc.
- How could the Moving Forward Making changes programme be improved?
    - Are there things you think there should be more of? Why is that?
    - Are there things you think there should be less of? Why is that?
- If you could describe the programme to someone else who was just starting out, what would you say? What would you tell them about it?

Future aspirations and summing up (5 mins)
Purpose: to understand how confident they feel that the programme will help them achieve their goals and what suggestions they have for improving it

Now thinking about the remainder of your time on the MF:MC programme….

- What are your aims for the rest of the programme / now you've left the programme? What would you like to achieve in the remainder of your time / in the future?
- How confident do you feel that this will happen? Why / why not?
- IF LEFT THE PROGRAMME – what happened after you finished MFMC? Did you have any ongoing contact with programme staff / other services? How did you feel about that? Helpful or not? Why / in what ways?
- Is there anything else you would like to say about the programme that we haven't covered? This could be good points or things you would like to change.

Close

- Any final questions from participant
- Thank participant and close interview
- Reiterate reassurances of confidentiality
- Pass on support leaflet of local and national services – explain to participant that it is standard practice for us to give out at the end of interviews.

Case Manager topic guide

Introduction

- Thanks for taking part
- Introduce self, Ipsos MORI and the evaluation (on behalf of Scottish Government, feeding into application to reaccreditation by SAPOR, interviewing men, staff and key professionals, reporting in January 2018)
- Duration of interview (approx. 45 minutes, depending on how much they have to say)
- Topics we want to discuss
- Confidentiality – won't use any names in reports or refer to location if quote professionals directly
- Recording – for Ipsos MORI use only, will be securely stored and deleted after project. Check consent to record?
- Any questions?

Participant's role and contact with the MFMC programme

- I'd like to start by finding out a bit more about your role in general and on MF:MC specifically – can you tell me a bit about that?
    - Probe on:
        - How MF:MC fits into wider role?
        - Caseload of MF:MC men (what % of total caseload is this?)
        - Time allocated to/spent on MF:MC vs. other elements of job?
        - Whether support clients on other, similar programmes too?
- And can you tell me a little bit about what your involvement in MF:MC involves?
    - Probe on whether involved / in what way at each stage:
        - Risk assessment – do they have any involvement in carrying these out pre or post MFMC?
        - Pre-group preparation?
        - During group stage?
        - After programme finishes / maintenance?

Joint working with MF:MC

- How do you work with the MF:MC team that delivers the group programme in your area?
- Level of contact with MF:MC (frequency, intensity)
- Nature of contact
- From your perspective, how effective are current arrangements for liaison between yourself and the MF:MC team?
- What are the things that work well? Work less well?
- Are you happy with the frequency of updates you receive from the team throughout the programme?
- Are there any stages during the programme where communication between yourself and the team could be improved?
- (e.g. risk assessment, pre-group stages, on-going liaison throughout the programme, post group process)

Assessment process

- Now thinking in a bit more detail about your different roles throughout the programme. How effective do you find the risk assessment process in determining men's suitability for the programme?
- Is it reaching the right groups of men?
- If not, why not / who is missing? How could it reach them more effectively?
- Do you feel that there are sufficient places available on the programme for offenders?
- How common is it for men to refuse to take part in the programme?
- If yes – why do you think this is? What are their reasons for doing so?
- Are there any particular groups of men more or less likely to do so?
- Are there particular groups of men more or less likely to engage with the programme once referred?
    - Why? Probe on individual reasons vs system reasons – i.e. anything about how the programme is delivered that contributes to disengagement?
    - Are there particular points / particular modules where men tend to disengage/drop out? Why?

Case management

- Thinking now about case managing individuals while they are on the programme. How well does the programme integrate with your other case management duties?
    - e.g. Good Lives and Keep Safe planning?
- Are there any areas or stages of the programme which can be more challenging in terms of case managing an individual?
    - e.g. any stages where additional support is required for some groups of men; any particular modules that can be problematic; ongoing risk assessment; post group process?

Post programme

- And now thinking about the post programme process. How useful is the post programme report from the MF:MC team in terms of informing ongoing treatment and goals for the individual?
- *Community based:* And how useful are the report feedback sessions delivered by the programme practitioners to participants?
- IF CM COMPLETES THE POST-PROG RISK ASSESSMENTS - Do you have any issues with the timescales involved in completing the (Stable 2007) risk assessments following completion of the programme? Why? What timescales are feasible in practice?

Perceived impact of the Programme

- How effective, overall, do you feel the MFMC programme is?
    - Why? *(Probe fully – find out what they are basing views on – direct observation, feedback from participants, feedback from colleagues, or what?)*
    - Positives/negatives?
    - What works well / less well?
    - Is it more or less effective for different types of men? Different types of offence? Different cognitive abilities? Why?
- How does MFMC compare to other programmes that work with male sexual offenders? Or other kinds of offenders? (e.g. Caledonian)
    - How, if at all, is it different from these services/interventions?
    - Aspects of MF:MC they think compare well / less well with other services? Reasons for saying that?
- What could be improved?

Other changes?

- Are there any stages in the programme where you feel you require more support from the MF:MC team?
- Are there any other areas where they feel the MF:MC, or the way it operates locally, could be improved? How? Probe fully.

THANK AND CLOSE. ASK FOR PERMISSION TO EMAIL/RING IF ANY FOLLOW-UP QUERIES.

Other stakeholders topic guide

Introduction

- Thanks for taking part
- Introduce self, Ipsos MORI and the evaluation (on behalf of Scottish Government, feeding into application to reaccreditation by SAPOR, interviewing men, staff and key professionals, reporting in January 2018)
- Duration of interview (approx. 30 mins depending on how much you have to say)
- Topics we want to discuss
- Confidentiality – won't use any names in reports or refer to location if quote professionals directly
- Recording – for Ipsos MORI use only, will be securely stored and deleted after project. Check consent to record?
- Any questions?

Participant's role and contact with the MFMC programme

- I'd like to start by finding out a bit more about your role in general – can you tell me a bit about that?
- Different people we are speaking to have different levels of contact with and knowledge about the Moving Forward: Making changes programme. How much contact do you have with MF:MC?
    - Probe for details around:
        - When first heard about MF:MC
        - Level of contact with MF:MC (frequency, intensity)
        - Who they / their organisation usually have contact with (Particular staff? Participants?)
        - When have contact? In what context?
        - How contact with MF:MC fits into their wider job / role?

Overview of knowledge of MF:MC

- Probe around understanding of:
    - What it's trying to achieve?
    - How it is delivered?
    - How does it fit into what else delivered locally relating to sexual offenders?

NHS stakeholders ONLY

- During which stages of the programme do you typically provide support and input to the programme?
    - Probe: initial risk assessment stage; psychometric assessments (pre and/or post); Healthy Sexual Functioning module; supporting staff on how to deal with participant issues (e.g. mental health, psychopathology).
    - For each stage they are involved in, probe:
        - What works well in terms of joint working with MF:MC?
        - Any issues or challenges faced in terms of your involvement with this stage?
        - In terms of working with MF:MC team at this stage, anything that could be improved?

OTHER STAKEHOLDERS - Joint working with MF:MC

- From your perspective, how effective are current arrangements for liaison between you / your organisation and the MF:MC team?
    - e.g. referral routes to/from MF:MC, joint working protocols, etc.
    - What are the things that work well?
    - What are the areas that could be improved?

Perceived impact of the Programme

The Moving Forward: Making changes programme attempts to reduce the re-offending of men convicted of sexual offences and increase their opportunities and capabilities for meeting needs by non-offending means. From what you've seen, what, if any, impact do you think it is having on offenders?

- How effective, overall, do you feel the MFMC programme is?
    - Why? *(Probe fully – find out what they are basing views on – direct observation, feedback from participants, feedback from colleagues, or what?)*
    - Positives/negatives?
    - What works well / less well?
    - Is it more or less effective for different types of men? Different types of offence? Different cognitive abilities? Why?
- From what they know, is it reaching the right men?
    - If not, why not / who is it missing? How could it reach them more effectively?
- How does MFMC compare to other programmes that work with male sexual offenders? Or other kinds of offenders? (e.g. Caledonian)

- How, if at all, is it different from these services/interventions?
- Aspects of MF:MC they think compare well / less well with other services? Reasons for saying that?

How does it compare to other services or interventions that work with:

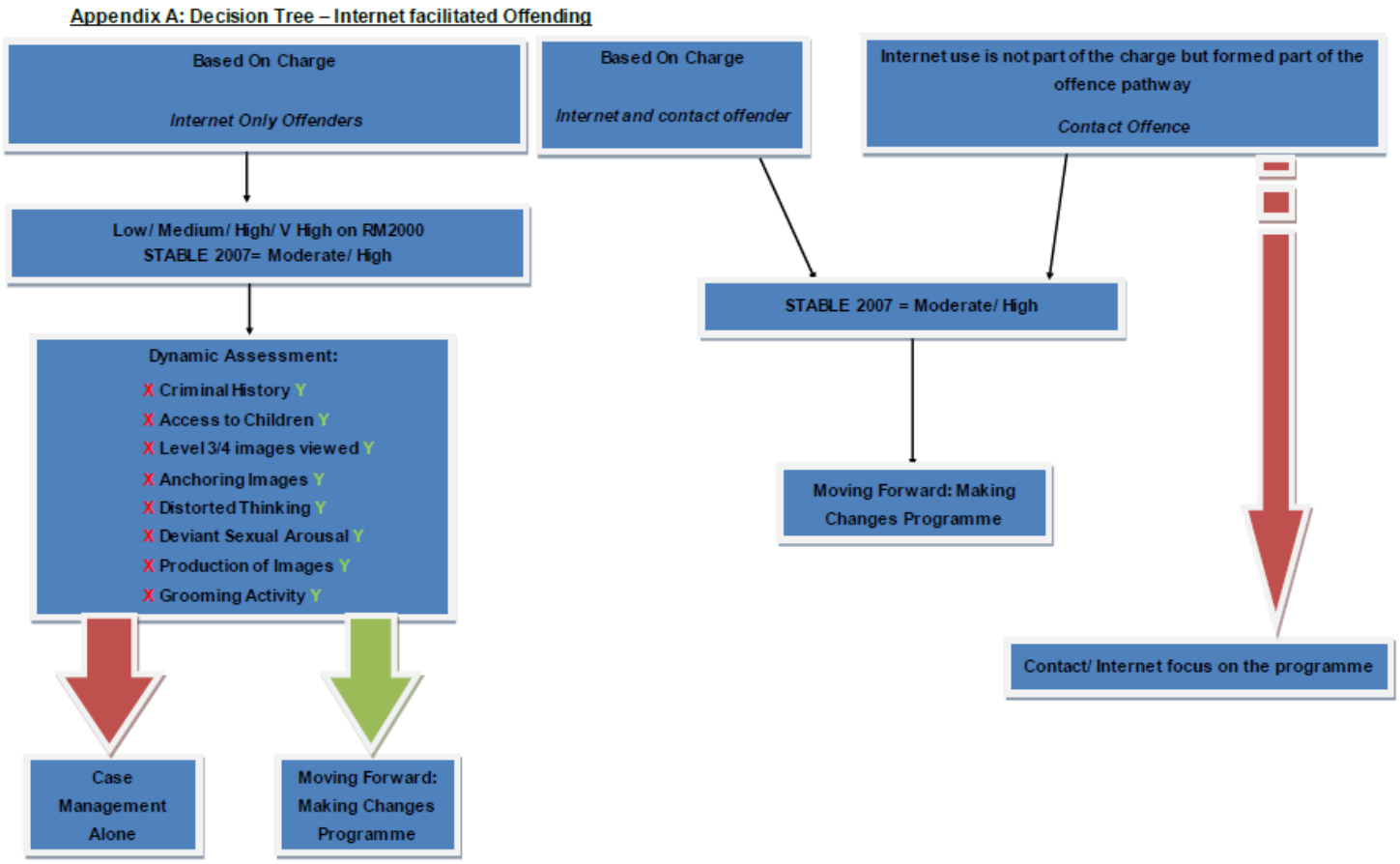
Other changes?

Are there any other areas where they feel the MF:MC, or the way it operates locally, could be improved? How? Probe fully.

THANK AND CLOSE. ASK FOR PERMISSION TO EMAIL/RING IF ANY FOLLOW-UP QUERIES.

Annex B – Internet offender 'decision tree'

Figure B.1 Internet offender 'decision tree' (taken from MF:MC Assessment and Evaluation manual)



Annex C – Additional tables and figures

Table C.1: Proportion of men in each Stable 2007 band, pre-programme, by site

Delivery site	High	Moderate	Low	*Base*
Aberdeenshire	27%	72%	1%	*181*
Dumfries & Galloway	26%	67%	7%	*42*
Dundee	27%	73%	0%	*56*
Fife	16%	82%	2%	*95*
Forth Valley	43%	57%	0%	*30*
Glasgow	17%	83%	0%	*36*
Lothian	21%	78%	2%	*63*
North Ayrshire	31%	65%	4%	*100*
North Lanarkshire	21%	79%	0%	*38*
Renfrewshire, Inverclyde and East Renfrewshire	17%	83%	0%	*76*
South Lanarkshire	16%	74%	11%	*19*
SPS	55%	41%	2%	*175*
Total	**30%**	**68%**	**2%**	**911**

Notes to table:

[1] Figures are based on all those who had started the programme and for whom a pre-programme SA07 score was available

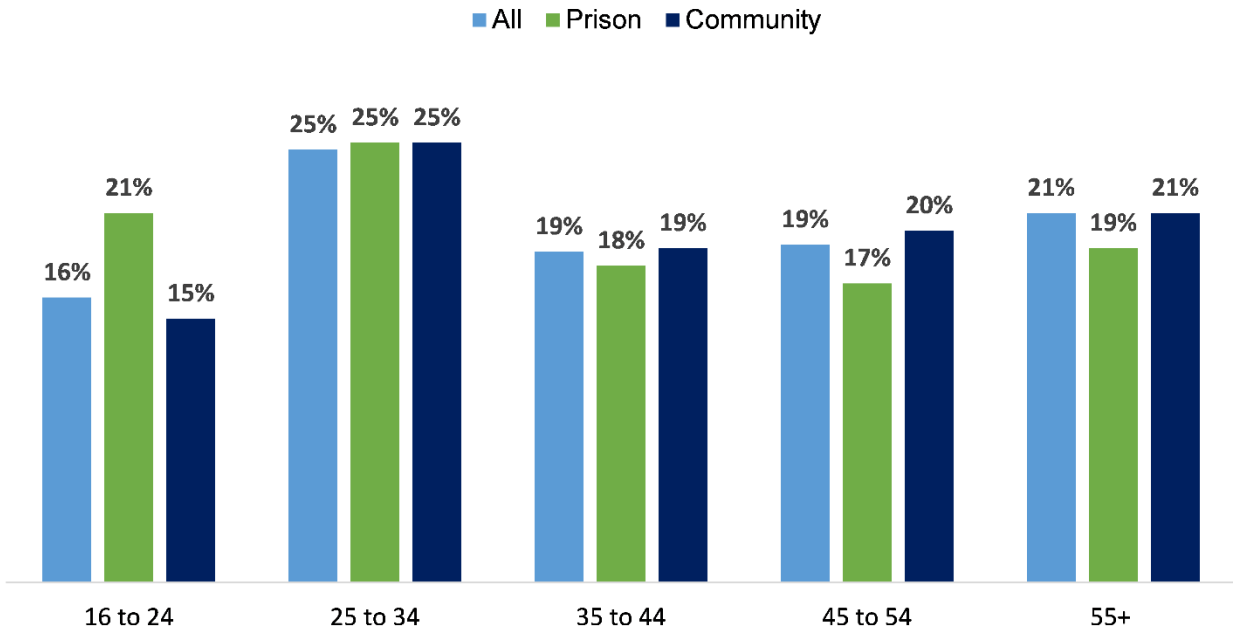
Table C.2: Number of men with a recorded MF:MC start date, by delivery site

Delivery site	Number of men recorded as starting on MF:MC
Aberdeenshire	181
Dumfries & Galloway	42
Dundee	56
Fife	95
Forth Valley	30
Glasgow	36
Lothian	63
North Ayrshire	100
North Lanarkshire	38
Renfrewshire, Inverclyde and East Renfrewshire	76
South Lanarkshire	19
SPS	175
Total	**911**

Notes to table:

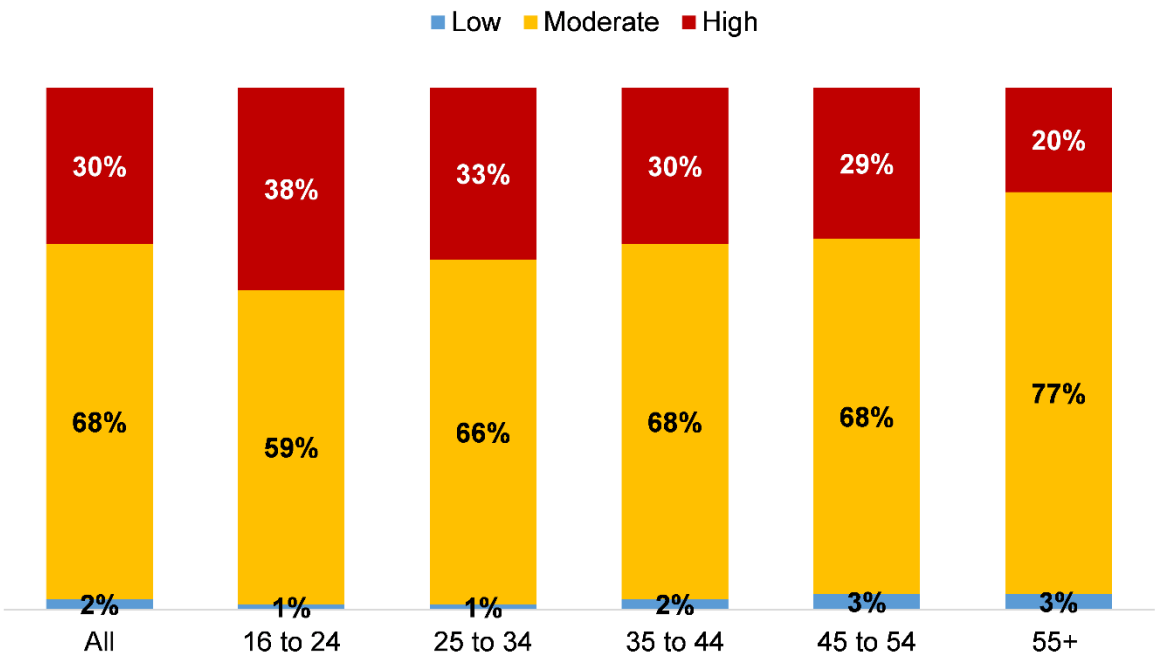
[1] Based on all men who have a starting date recorded in the data, and who were deemed as suitable for the programme. As discussed in Chapter 3 of this report, a number of sites were delivering MF:MC before the IT system was in place. Correspondence with Treatment Managers indicated that at least 50 men had started and completed the programme but are not accounted for in this data.

Figure C.1: Age profile of men starting the programme



Base: All who started the programme (911)

Figure C.2: Stable 2007 risk band within age band



Base: All who started the programme (911)

Table C.3: Stage at which men left the programme

Stage of removal	Number of men	% of men who left
Pre-programme psychometrics	5	5%
Mid-programme: Essential modules	27	28%
Mid-programme: Optional modules	10	10%
Post-programme psychometrics	1	1%
Post-programme risk assessment	3	3%
Post-programme exit interview	4	4%
Not stated	47	48%
Total	97	100%

Table C.4: Change in Stable 2007 mean scores, by types of men

	Change in Stable 2007 score between beginning and end (mean)	*Base*
All men	**-2.7**	***230***
Stable 2007 band at beginning - 1		
High	-4.0	*66*
Moderate	-2.2	*161*
Type of delivery site		
Community	-3.1	*165*
Prison	-1.4	*65*
Age group		
16 to 24	-2.3	*32*
25 to 44	-2.7	*111*
45 +	-2.8	*87*

Base: All those with a Stable 2007 score at beginning and end of programme

Notes to table:

1 - Those with “Low” initial Stable 2007 band are not shown, due to small sample size (n = 3)

Table C.5: Mean change in score on psychometric scales pre and post-programme, by whether score has improved, stayed the same, or got worse

	Scale	Improved (mean change in score)	Stayed the same (mean score)	Worse (mean change in score)	*Base*
Self-Compassion Scale	12-60	-34	35	+12	*228*
Social Problem Solving Inventory	0-20	-12	12	+3	*205*
Social and Emotional Problem Solving Scale for Adults (SELSA)					
SELSA 1 – Romantic (Loneliness/struggling with romantic relationships)	5-35	-20	22	+6	*205*
SELSA 2 – Family (Loneliness/struggling with family relationships)	5-35	-12	14	+10	*205*
SELSA 3 – Social (Loneliness/struggling with social relationships)	5-35	-17	20	+6	*205*
Locus of Control (LOC)					
LOC 1 – Internality (Belief that I control my life)	0-48	-27	31	+6	*205*
LOC 2 – Powerful others (Belief that powerful others control my life)	0-48	-18	20	+7	*205*
LOC 3 – Chance (Belief that my life is controlled by chance)	0-48	-17	21	+4	*205*
Barratt Impulsiveness Scale	30-120	-54	64	+5	*205*
Hostility Towards Women Scale	0-10	-2	1.3	+1	*205*
Sex with Children is Justifiable Scale	0-72	-10	4	+1.5	*205*
Paulhus Deception Scale	0-40	-11	9	+6	*205*
Self deception	0-20	-4	3	+3	*205*
Impression management	0-20	-8	7	5	*205*

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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