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**Health and social care staff responses to working with people with a learning disability who display sexual offending type behaviours**

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**Summary:** This study found that 59% of social care staff were currently supporting a client with a learning disability who had offended or displayed an offending type behaviour. The range of behaviours was similar to that displayed by clients in a secure health facility and included rape, sexual assault and exposure. Only 22.9% of social care staff had received training in this area, while none of the health staff had. Both groups expressed low levels of confidence in supporting this client group. The areas of difficulty were common to both groups and included personal attitudes and attitudes of others to the behaviour, and concern over risk, responsibility and safety. In respect of attitudes, social care staff were found to be significantly more likely to hold negative attitudes towards the person's behaviour, while health staff were significantly more likely to feel negatively towards the person. Health staff were significantly more likely to identify training as a means of further support, while social care staff identified professional input. Both groups identified the need for theoretical training about working with this client group. Despite this no significant differences were found between those who had and had not received training and confidence, attitudes and the need for further support.

**Key words:** staff responses. learning disability, sex offenders

## **Introduction**

Individuals with a learning disability who commit sex offences or engage in serious sexually inappropriate behaviour present a challenge to community care policies. In a number of cases social care staff are being required to support clients who display such behaviours in community homes (Thompson, 1997). Defining sexual offending in individuals with a learning disability is difficult as what would be considered 'offences' in the nondisabled population may not be reported to or dealt with by the legal system in the same way for people with a learning disability (O'Connor & Rose, 1998; Lyall et al, 1995). Research has indicated that sexual offending type behaviour is not always dealt with adequately by social care staff (Lyall et al., 1995) social work authorities and health trusts (Brown & Thompson, 1997) or the legal system (O'Connor & Rose, 1998). A study by McCarthy and Thompson (1997) found that in a high percentage of cases there had been minimal or no action taken in response to offending, particularly if the victim was female. Similarly, Lyall et al (1995) found a high tolerance of offences among social care staff, with one service indicating a reluctance to report rape. Such inadequate responses have been attributed to a number of factors:

- Difficulty in reaching agreement between the parties involved that the behaviour constitutes a 'legitimate problem' (Brown & Thompson, 1997)
- A lack of relevant policies and procedures relating to identifying and dealing with offences (Lyall et al 1995; Thompson, 1997)
- A belief that if the client lives in an existing health or social care provision they are already being adequately cared for (Carson, 1989)

- The belief that allegations will not be followed up by the legal system (Clare & Murphy, 1998)
- Minimisation of the behaviour by staff and families, particularly when the victim also has a learning disability (Brown et al., 1995)

This paper therefore refers to 'sexual offending type behaviours' and 'sexual offences' to differentiate between those same behaviours which have been dealt with differently by the legal system.

The difficulties outlined above highlight the role that staff and organisational factors play in the effective management of sex offending in people with a learning disability. This is increasingly being acknowledged by workers in this field, with an emphasis on environmental and service variables as components of treatment, in addition to approaches which focus on the offending behaviour of the client per se (Brown & Thompson, 1997; Clare & Murphy, 1998). Work by Day (1988) found that the provision of stable accommodation, a regular day placement or activities, and ongoing support were positively correlated with a successful outcome in offenders with a learning disability. Of the group of twenty offenders, eight had committed sex offences. This indicates an important role for the provision of high quality residential and day service provision. This would appear to be being recognised in clinical work. A recent study by Bremble and Rose (1999) of the approaches that clinical psychologists adopted with adults with a learning disability accused of sexual offending included both individual work and systemic work such as the provision of advice, support and guidelines to residential staff.

However, the provision of support to sex offenders has long been acknowledged as being demanding and challenging for the therapist. Erooga (1994) points out that the relationship between the therapist and client can be intense and involve complex and disturbing issues and topics. For example the therapist must simultaneously adopt a role that is supportive and empathic but that is not condoning of the client's behaviour. Such work also takes place in a social context where there is little agreement about the appropriate response to the offender's behaviour (O'Connor, 1997) or even if it should be treated and reported as an offence in the first place (Carson, 1989). Additionally, failure of therapy and subsequent re-offending has serious consequences for the victim and the offender, and the therapist may therefore feel an overwhelming burden of responsibility. As a result the therapist may develop a number of intense and conflicting emotions towards the offender, which may impede therapeutic work (Stanley, 1996) and lead to burn-out (Farrenkopf, 1992) or secondary post-traumatic stress (Kearns, 1995).

The difficulties involved in working with offenders are acknowledged in recommendations that therapists receive regular support and supervision, are adequately trained for the role and undertake a period of self-reflection about the impact such work may have on them before they undertake it (Kearns, 1995). By contrast, social care staff supporting clients with a learning disability may fail to have even a basic knowledge about this client group (McKenzie et al., 1999). and, given the specialist nature of forensic work, are less likely to have received training and support in relation to people with a learning disability who sexually offend. It is therefore probable that social care staff are as, or more, likely to experience the same negative effects as therapists who support this client group. The impact on social care staff of supporting offenders with a learning disability, however, is less well documented, despite the fact that this staff group spend proportionately more time caring for offenders.

Clare and Murphy (1998) note that carers may feel resentful about the time and attention the client receives as a result of their offending. Similarly, Thompson and Brown (1997) note that staff denial or misunderstanding of the nature of sex offending work can lead to barriers in implementing an effective care plan. The emotional impact of such work on social care staff, however, remains unclear. This study therefore aimed to examine the following:

- The number of social care staff who have supported or currently support a client with a learning disability who displays sexual offending or sexual offending type behaviour and who have received training in this area.
- Staff feelings towards the client and his behaviour.
- Staff confidence and areas of difficulty in supporting clients with such behaviours and strategies that would make this job easier.

In addition, social care staff responses were compared with health staff working in specialist services for clients with a learning disability who offend.

## **Method**

Ninety-six individuals participated from two service settings with which the authors had routine contact in a professional capacity, either as part of a community learning disability team or specialist forensic learning disability service. The two groups were social care staff (n=81) and nursing staff (n=15). The social care staff were employed by non-statutory housing agencies to provide residential support to clients with a learning disability. Nursing staff were employed by the health service to provide medium security accommodation to sex offenders with a learning disability in a community setting. This setting was for offenders detained under mental health legislation who were not considered to require the levels of security provided by special hospitals or forensic units. The nursing staff had the responsibility of providing 24 hour supervision and support to clients.

All staff were assured that participation was voluntary and were asked to complete an anonymous questionnaire which asked the following:

- Do you support a person who has committed a sexual offence or offending-type behaviour ? If yes, please state the type of behaviour.
- Have you received training in managing this type of behaviour ?
- What do you find most difficult about supporting this client group?
- How do you feel about the sexual behaviour of the person?
- How do you feel about the person?
- What do you feel could make supporting this client group easier?
- Which areas (if any) do you feel you need further training in?

Participants were also asked to note their age, gender and number of years of working in learning disability services. In addition they were asked to rate both their confidence and level of difficulty in supporting this client group as compared to clients with other forms of challenging behaviour on a visual analogue scale. The 'confidence' scale ranged from 0 (not confident at all) to 4 (totally confident). The 'difficulty' scale ranged from 0 (much easier) to 5 (much more difficult). Twenty questionnaires (21%) were scored by two raters to give an indication of inter-rater reliability.

## **Results**

All social care staff who were approached agreed to participate. while 15 out of 22 health care staff completed the questionnaire, giving a response rate of 68%. Forty eight (59%) of social care staff were supporting a client who had offended/had a sexual offending type behaviour. All of the health care staff, by definition, supported this group. The following data applies to these participants only. The mean age of the social care staff was 36.7 years (SD =

9.3) and of the health staff was 33.8 (SD = 7.6). Of the social care staff 28 were female and 20 male, while 9 of the health care staff were female and 6 male. No significant differences were found between the gender or age of the two groups. The social care staff had a mean number of years of experience of working in learning disability services of 8.2 (SD = 5.91) and the health staff had a mean of 13.6 (SD = 5.79). Health staff were found to have significantly more experience ( $t=-3.03$ ;  $df= 59$ ;  $p<0.01$ ).

### *Types of offences*

Table 1 illustrates that the most common form of sexual offence displayed by clients supported by both health and social care staff was sexual assault of adults, with a high proportion of both groups also displaying sexual attraction towards and assault of children.

### *Training*

Eleven (22.9%) of the social care staff had received training in working with sex offenders with a learning disability, while none of the health care staff had. Social care staff were therefore significantly more likely to have received training. ( $\chi^2 = 4.17$ ;  $df=1$ ;  $P<0.01$ ).

### *Confidence in supporting this client group*

The mean rating of confidence for social care staff was 1.47 (SD= 0.77) and for health staff 2.31 (SD = 0.69) with 0 = no confidence at all and 4 = total confidence.

### *Difficulty in Supporting the client group*

The social care staff had a mean rating of 3.2 (SD = 0.72). and health staff a mean rating of 2.72 (SD = 0.48). A t-test demonstrated that social care staff found working with this client group significantly more difficult than health staff ( $t= 2.38$ ;  $df=60$ ;  $p< 0 . 0 5$  ).

Table 2 illustrates that both social care and health care staff' experienced the greatest difficulty in dealing with their own negative attitude towards the offender, the negative attitudes of others and the tendency of the offender to minimise their responsibility for and seriousness of the offence. In addition, while safety was of concern to both groups, the social care staff were significantly more likely than health staff to find safety issues difficult when supporting this client group ( $\chi^2 = 3.91$ ;  $df=1$ ;  $p<0.05$ ).

#### *Feelings towards the person's behaviour and towards the person*

Table 3 illustrates staff feelings towards the client's behaviour and towards the person. A relatively high percentage of both groups responded to this question by expressing a wish to have a greater understanding of the causes of the client's behaviour. In respect of attitudes, social care staff were significantly more likely than health staff to hold a negative attitude towards the behaviour ( $\chi^2 = 15.85$ ;  $df=1$ ;  $p<0.01$ ), while health staff were significantly more likely to hold a negative attitude towards the person ( $\chi^2 = 5.72$ ;  $df=1$ ;  $p<0.05$ ). Negative attitudes included disgust, anger, dislike, fear, disappointment and upset, while positive attitudes included liking, empathy and sympathy.

#### *Areas of support identified by staff*

Table 4 illustrates the areas of support identified by staff as likely to make supporting this client group easier. A high percentage of both health and social care staff identified the need for training in this area. However, health staff were significantly more likely than social care staff to identify the need for training ( $\chi^2 = 5.01$ ;  $df=1$ ;  $p<0.05$ ) while social care staff were significantly more likely to identify the need for professional input ( $\chi^2 = 4.49$ ;  $df=1$ ;  $p<0.05$ ) including assessment and therapeutic interventions.

### *Training*

Table 5 illustrates the areas in which staff felt they required further training to support this client group. In relation to training, both groups placed highest priority on receiving input about the theoretical basis of, and therapeutic approaches to, sex offending in clients with a learning disability.

### *The impact of previous training on staff*

No significant differences were found in gender, age or years of experience between those who had received training and those who had not. Despite the emphasis placed on training by both groups, no significant differences were found in expressed levels of confidence or perceived difficulty in working with this client group between those who had received training and those who had not. No significant relationships were found between training and attitudes towards the behaviour or person, area of difficulty or need for support and training.

### *Experience*

Overall, a significant relationship was found between the number of years of experience and how confident the individual felt in supporting this client group (1-tailed,  $r = 0.22$ ;  $p < 0.05$ ), with those who were more experienced being more confident. This did not hold true for the social care group or health group alone.

### *Inter-rater reliability*

Kappa values for all categories were significant at  $p < 0.01$ , indicating significant inter-rater reliability.

## **Discussion**

The most striking finding of this study was the large percentage of the social care staff group (59%) who were supporting a client who had committed a sexual offence or displayed sexual offending type behaviours. Moreover, the range of behaviours were similar in nature to those displayed by individuals detained under the Mental Health Act at the health care houses, and included rape, sexual assault and exposure. Only eleven (22.9%) of the social care staff had received training in working with sex offenders with a learning disability. However, of more concern was the fact that none of the health care staff had. This is despite the fact that this is a specialist facility for individuals with a learning disability who have committed sexual offences. This may be due to the fact that the houses receive specialist input from a clinical psychologist, and that, because the facility is secure and clients remain there long term, staff may receive input tailored to the individual.

Both health and social care staff, however, had low levels of confidence and experienced some difficulty in supporting this client group. Social care staff found the task significantly more difficult. This is likely to be a realistic reflection of the complex and challenging nature of working with sex offenders outlined by a number of workers in the field (Kearns, 1995). The main areas of difficulty for both groups were in relation to the attitudes of others and personal attitudes towards the offenders and safety issues. This was particularly significant for social care staff, perhaps reflecting the fact that the health workers worked in a secure facility, where individuals were detained under the Mental Health Act and could therefore legitimately be supervised. Previous authors have commented on the burden of failure and responsibility felt by therapists working in this area (Stanley, 1996). Such feelings would also appear to be pertinent to social care staff.

Both health and social care staff also experienced a range of reactions both to the clients and their behaviour. Significant differences were found between the two groups, however. Social care staff were significantly more likely than health staff to hold a negative attitude towards the client's behaviour, such as disgust, while health staff were significantly more likely to hold a negative attitude towards the person, such as anger. It is unclear why this should be the case. It may reflect a difference in the severity of the behaviours that both groups deal with, although both supported clients with a similar range of behaviours. Alternatively, the difference may result from the different roles that each group play. Health staff are likely to be undertaking on-going therapeutic work which requires them to know the details of offences. In addition, they may be more likely to be faced with denial of, and rationalisations about, the offending factors which are often associated with work with sex offenders (Lindsay et al, 1999). This may lead to more anger and negative feelings towards the offender than is felt by social care staff who are not undertaking direct therapeutic work.

Negative feelings such as anger have been found to be common in therapists working in this field but if they are not addressed they can be harmful to an effective therapeutic relationship (Peaslee, 1995). Previous work has suggested that training, increased experience in the area, and the provision of a service in the context of a specialist multi-disciplinary team can help minimise these negative feelings (Peaslee, 1995). The provision of training and on-going support to staff has also been recommended to ensure that staff denial and misunderstanding do not present barriers to implementing effective care approaches (Thompson & Brown, 1997). A high percentage of both health and social care staff in this study identified the need for training and professional input as means of support, with health staff being significantly more likely to emphasise training and social care staff to identify professional input. These

differences are likely to arise from the fact, as noted above, that while the health staff received specialist support, none of them had received training. By contrast, the social care staff were significantly more likely to have received training but they were less likely to receive such regular, intensive professional support.

In terms of training, both groups emphasised the need for theoretical training in relation to sex offending in this client group. Despite this, this study found that previous training had had no impact on levels of expressed confidence or perceived difficulty in working with this group. Similarly, training did not appear to impact on attitudes or the need for additional support or training. This may be related to the type of training which the staff had received. It is acknowledged that working with sex offenders with a learning disability is complex and challenging, requiring a multiagency, multi-disciplinary approach (Brown & Thompson, 1997; Clare & Murphy, 1998). The provision of a wide range of therapeutic approaches (Lindsay et al 1999) also requires a high level of professional expertise. It is therefore possible that while staff had received training in some broad aspects of this area, this had been insufficient to change their attitudes and levels of confidence.

In summary, this study would suggest that a high percentage of social care staff are being expected to support this client group with insufficient knowledge and training in the area. In addition, while the remit of health and social care staff in working with offenders differs, with health staff taking on a more therapeutic role and social care staff undertaking a risk management role, both groups in this study experienced similar difficulties and needs in working in this area. A number of authors have argued for services to develop consistent and multidisciplinary approaches to working with sex offenders (Brown & Thompson, 1997) and have stressed the need to involve carers in this process (Clare & Murphy, 1998). Such

involvement includes the need to listen to and address carers' concerns; explain the rationale for working with the person and the time-scale involved to ensure realistic expectations; ensure that all carers are aware of what has been agreed and the part they play in minimising the risk of re-offending (Clare & Murphy, 1998). This study suggests that a number of staff concerns require to be addressed before a consistent, multi-disciplinary, multiagency approach to sex offenders with a learning disability can be achieved.

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*Table 1: Type of behaviours exhibited by clients supported by social care and health staff.*

Category of behaviour	Social Care		Health Care		Total	
	N	%	N	%	N	%
Sexual Assault-adults	22	45.8	9	69.2	31	50.8
Sexual attraction towards minors	16	33.3	9	69.2	25	41
Sexual assault-children	8	16.7	11	84.6	19	31.1
Exposure	18	37.5	1	7.7	19	31.1
Verbal threat, sexual	11	22.9	2	15.4	13	21.3
Inappropriate masturbation	13	27.1	0	0	13	21.3
Rape	3	6.3	3	23.1	6	9.8

*Table 2: Areas of difficulty in supporting this client group identified by social care and health staff*

Category of behaviour	Social Care		Health Care		Total	
	N	%	N	%	N	%
No difficulty	1	2.1	2	13.3	3	4.8
Lack of information/ training/ support	4	8.5	2	13.3	6	9.7
Attitude <sup>1</sup>	28	59.6	11	73.3	39	62.9
Safety issues <sup>2</sup>	23	48.9	3	20	26	41.9

1. negative attitude of staff, public, others/minimising attitude of offender.

2. responsibility for safety, risk of re-offending, need to after clients' behaviour.

*Table 3: Social care and health staff feelings towards the client's behaviour and the client*

	Attitude towards behaviour				Attitude towards the person			
	Social care		Health		Social care		Health	
	N	%	N	%	N	%	N	%
Negative attitude	30	62.5	0	0	13	28.9	9	64.3
Positive attitude	0	0	0	0	34	75.6	8	57.1
Attempt to understand	16	36.4	6	40	0	0	0	0
Concern re risk/safety	6	13.6	8	53.3	0	0	0	0
Other	0	0	0	0	3	6.7	0	0
No problem	2	4.5	1	6.7	0	0	0	0

*Table 4: Areas of support identified by staff*

Areas of Support	Social Care		Health	
	N	%	N	%
Training	18	4	11	73.3
Professional input	11	24.4	0	0
Police support	1	2.2	0	0
Background knowledge re offender	2	4.4	0	0
Peer support	9	20	2	13.3
Discussion with offender	3	6.7	0	0
Clear guidelines	9	20	2	13.3

*Table 5: Areas of training need identified by staff*

Area of support	Social care		Health care	
	N	%	N	%
All areas	7	16.7	1	6.7
Theoretical re: offending	23	54.8	10	66.7
Sexuality	12	28.6	3	20
Counselling	6	14.3	2	13.3