UNIVERSITY OF LEEDS

This is a repository copy of *Forio: a Swiss treatment program for young sex offenders with intellectual disabilities*.

White Rose Research Online URL for this paper:
http://eprints.whiterose.ac.uk/142823/

Version: Accepted Version

Article:
Hollomotz, A orcid.org/0000-0003-3496-3924 and Schmitz, SC (2018) Forio: a Swiss treatment program for young sex offenders with intellectual disabilities. Journal of Intellectual Disabilities and Offending Behaviour, 9 (3). pp. 117-127. ISSN 2050-8824

https://doi.org/10.1108/JIDOB-05-2018-0007

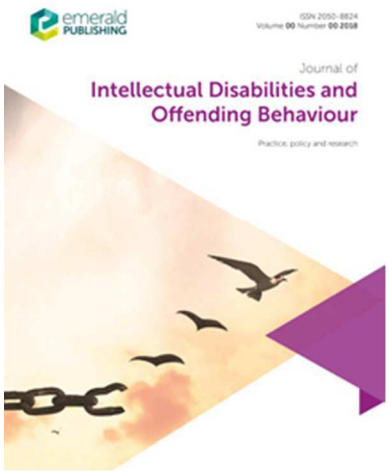
© Emerald Publishing Limited 2018 Published by Emerald Publishing Limited Licensed re-use rights only. This is an author produced version of a paper published in Journal of Intellectual Disabilities and Offending Behaviour. Uploaded in accordance with the publisher's self-archiving policy.

Reuse
Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown
If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

White Rose university consortium
Universities of Leeds, Sheffield & York

eprints@whiterose.ac.uk
https://eprints.whiterose.ac.uk/



Forio: A Swiss treatment program for young sex offenders with intellectual disabilities

Journal:	*Journal of Intellectual Disabilities and Offending Behavior*
Manuscript ID	JIDOB-05-2018-0007.R1
Manuscript Type:	Research Paper
Keywords:	Adapted sex offender treatment program, disabled offenders, harmful sexual behaviour, offenders with learning disabilities, sexual offending, community risk management

SCHOLARONE™
Manuscripts

Forio: A Swiss treatment program for young sex offenders with intellectual disabilities

Abstract

Purpose: This paper provides a description of a Swiss outpatient group therapy for adolescent and young men with intellectual disabilities who have sexually offended.

Design/ methodology/ approach: The findings from two studies that examined the treatment independently from one another are brought together. These combine the qualitative methods of document analysis of program tools, overt participant observations of treatment sessions and semi-structured interviews with program designers.

Findings: At the heart of Forio treatment is a 7-step program that aims to enable participants to increase their risk management capacities and foster pro-social behaviours. Responsivity issues are a key consideration and the use of a traffic light system to distinguish acceptable, borderline and unacceptable behaviours provides a central reference point throughout treatment and beyond. Treatment relies on individuals practicing newly learned pro-social behaviours in their daily life. To facilitate this, risks are managed, and support provided via close networking between therapists and the supervision and social care network.

Practical implications: This paper offers detailed descriptions of the program setting, structure and tools, which will allow international readers to adapt the techniques discussed to suit their specific treatment context. Particularly the close networking between treatment providers and those managing risks in the community is commendable.

Originality/ Value: The Forio program has not previously been described in English language papers. Even though it arises from the same evidence base as the internationally more widely known programs, this paper offers unique insights into ways in which known concepts have been adapted to suit local circumstances.

Introduction

In 1995 Switzerland's first group treatment for adolescents who have sexually offended was developed within the child and adolescence psychiatric services Thurgau. This was based on the

Journal of Intellectual Disabilities and Offending Behav

work of Dutch psychotherapist Ruud Bullens (e.g. Bullens, 1993, 1994). As demand for this treatment soon exceeded capacity, two therapists eventually founded a dedicated outpatient service in 2004, the *Forensiches Institut Ostschweiz*[1], Forio. Here, an additional program that targets the learning needs of adolescents and young people with intellectual disabilities was developed. This was inspired by the UK based G-MAP program for adolescents (O'Callaghan, 2004), which was modified from the US based old me/ new me model (Haaven, Little, & Petre-Miller, 1990).

This in turn is underpinned by a theory of positive psychology in that they encouraged the men to grow and develop personally, so that they could strive towards a better, offence-free future. The basic idea is that every person has 'old me' thoughts, actions and behaviours in them and offending happens when these are strongest. Each of us also has a repertoire of 'new me' or pro-social thoughts, actions and behaviours and the object of treatment is to make 'new me' stronger to enable self-management. G-MAP modified this concept into New Life/ Old Life and this recognises that the social structures around a person can help or hinder the change process (O'Callaghan, 2004). As will be shown, Forio's strength lies in working with individual's social and professional networks to support the building of new, offence-free lives worth living. An international program with similar roots to Forio is the WellStop program in New Zealand, which emphasizes that everyone has a 'good side' and a 'bad side'. Treatment encourages individuals to become aware of, grow and maintain their 'good side', drawing on external support where necessary (Ayland & West, 2006).

Evaluations of the effectiveness of psychological approaches in the treatment of sex offenders with intellectual disabilities tend to measure progress on several therapeutic outcomes, including victim empathy, sexual knowledge, changes in attitudes consistent with sex offending, cognitive distortions and problem sexual behaviours. However, there continue to be inconsistent findings in respect to reductions in sexual reoffending longer-term, leading the authors of three independent systematic reviews to concluded that there is currently limited evidence of the 'effectiveness' of the programs (Cohen & Harvey, 2016; Jones & Chaplin, 2017; Marotta, 2017). The literature in this field is assessed as underdeveloped and these authors argue that there is a strong case for further research.

The Forio treatment aims for the same therapeutic outcomes as those captured by the above reviews. This paper offers a detailed description of this program, with the aim to add to the growing catalogue of known international interventions. Forio has not previously been described in English language outputs and it is therefore not known to international readers outside the German-speaking regions. It is hoped that learning about some of the unique program tools and ways of

[1] For further information, see: https://www.forio.ch/

Journal of Intellectual Disabilities and Offending Behav

working may help to inspire international readers to adapt these to suits their specific treatment context.

Methodology

This paper is written by two researchers who conducted separate evaluations of the Forio program. However, this paper does not offer a program evaluation and separate publications featuring patient data are currently in draft by both authors. Before the evaluations could begin the researchers had to immerse themselves in the program, to fully understand how it is intended to work, as there is currently no published treatment manual. This collaborative paper summarises these initial findings and the methods described here relate to the initial stages of both projects.

Study 1

The second author conducted a comprehensive desk-based review of practitioner guidelines for the therapy sessions, a range of notes and teaching materials used for training practitioners, case documentations and papers and conference presentations authored by those who have designed the treatment. On the basis of the above, an interview guide was designed in line with the approach outlined by Helfferich (2011), who recommends following these steps: Questions are collected at first, then examined, in order to reduce these and to structure the questionnaire. The remaining questions are (re)arranged and a final prompt sheet is drafted.

Two comprehensive semi-structured expert interviews were conducted with the two practitioners who designed the program. Both were asked questions regarding the program goals, decisive factors for and effectiveness of the program, collaboration with the social care system, feedback on engagement of patients and their social care system, and about any modifications to the program since it started. Additionally, one of the respondents, who is still involved in the delivery of the program, was asked a second set of (in-depth) questions concerning its implementation. The interviews were recorded and (partially) transcribed. Subsequently, a first description of the program and its components was drafted.

Study 2

The first author was able to draw on the comprehensive scoping study that was conducted by the second author to familiarise themselves with the program before they conducted a two-week

Journal of Intellectual Disabilities and Offending Behav

fieldtrip to Forio. As an overt participant observer (Watt & Scott-Jones, 2010), they attended altogether four staff meetings, observed ten group and two individual treatment sessions, as well as a 'risk-cycle' meeting. They furthermore visited two institutions, which work with Forio clients. They attended the daily informal lunchtime gatherings of Forio staff and spent many hours informally discussing what they had observed with staff as and when opportunities arose.

After the first week of intense observations and discussions the first author developed a draft summary of key elements of the Forio program, a refined version of which is presented in figure 3 towards the end of this paper. This was presented at the staff meeting at the start of the second week. Staff critically appraised this draft, which resulted in further refinements. This process of re-drafting continued throughout the second week, following further observations and informal discussions. Towards the end of the two weeks semi-structured interviews were conducted with the two staff who designed the programs, following the format of the realist interview (Manzano, 2016). The emphasis was on testing and refining the draft program theory further.

Ethics

Ethical permission to conduct these studies has been granted by appropriate ethics boards in Switzerland.

Program description

The first section introduces the Forio treatment context, including its setting in Switzerland. Next, the treatment model and philosophy are briefly outlined before the seven-step program that underpins the treatment is described. This is followed by an overview of the structure of the treatment sessions. Finally, the key role that the supervision and social care network plays throughout treatment and beyond is exposed.

Context: People with intellectual disabilities in rural Switzerland

At 8.2 million inhabitants, Switzerland has a similar population size to Greater London (8.7 million) and New York City (8.4 million). This comparatively small population size spread across an area of 41,285 km² results in the availability of fewer specialised services compared to Anglo-American regions, as the numbers using them would be so low that services would not be economically viable. For instance, Switzerland does not have any long-stay secure forensic accommodation for people

nal of Intellectual Disabilities and Offending Behav

with intellectual disabilities. This means that instances in which a person needs forensic care are approached on a case-by-case basis and whenever possible managed within the existing social care system.

The Canton of Thurgau is situated in rural north-east Switzerland. Here, living with relatives or institutional living are the main options for those people with intellectual disabilities who require support with daily living. Living units are broken down into flats with private bedrooms and communal areas for living and socialising. The institution is often also a place of work and where residents spend a large proportion of their leisure time. Many people grow old and die here (BFS, 2012). Yet, these institutions do not fall neatly into the category of 'total institutions' (Foucault, 1977), which would be a place of work and residence for a great number of similarly situated people, who are cut off from the wider community. Albeit self-sufficient, Swiss institutions are not entirely cut off. Residents are free to access the community, with support when needed. Depending on risk, many of the Forio patients who live in an institution travel independently to their weekly treatment group or to visit their families. In fact, the community is where a proportion of such patients have committed their index offence.

Treatment model and philosophy

This paper focusses on the treatment groups for juvenile and young adult males, with ages ranging between 14-34 years old. They have committed mostly contact sexual offences. Treatment is aimed at people with IQ ranges 60-80, but in addition to the programme described here Forio also deliver treatment for those with IQ below 60. The treatment is in line with the risk-need-responsivity model (Andrews, Bonta, & Hoge, 1990), as follows:

Risk principle: Only those with a medium to high risk are treated.

Need principle: Criminogenic and non-criminogenic needs that are common amongst juveniles and young men with medium to high risk are addressed in group. Those whose support needs unravel as more complex are at times offered additional support or diverted to 1:1 therapy.

Responsivity principle: One of the co-therapists is a psychologist, the other a special educational needs teacher (Fischer & Renner, 2015). Their focus is to ensure that the intervention is tailored to suit the diverse learning styles of the young men and to ensure that the treatment content is understood.

Journal of Intellectual Disabilities and Offending Behav

The treatment has a strength-based focus with an emphasis on warmth, empathy, and support for the young men (William L Marshall, Marshall, Serran, & O'Brien, 2011). Therapists aim to offer a comfortable and at the same time challenging atmosphere. This is summed up by the phrase '*more holding and support, less challenge'* (Schmelzle, 2015). 'Holding' is intended to create a sanctuary within which psychological development is possible (Winnicott, 1965). This focus is deliberate in the context of delict-oriented treatment, as this is at risk of becoming confrontational. Schmelzle (2015) argues that, even when a person has caused significant harm, a supportive and 'holding' treatment atmosphere is more likely to lead to success. 'Challenge' means that therapists should ensure that participants will never disengage during this process. They should expect to be called on at any time during the session. This means that they are in a constant state of activation. About two thirds of the young men attend treatment by court order. Schmelzle (2015) argues that this legal context enforces a framework of liability within which aversive or uncomfortable issues can be tackled.

Finally, the treatment incorporates elements of cognitive behavioural therapy (CBT). The program designers argue that CBT makes the program objectives more tangible for patients with intellectual disabilities. CBT is underpinned by three fundamental propositions. Those are that cognitive activity (1) affects behaviour and that (2) it may be monitored and altered. Moreover, (3) 'desired behaviour change may be effected through cognitive change' (Dobson & Dozios, 2010, p. 4). CBT based group programs have first been used for offenders with IQ above 80 and then developed further to address the learning needs of those with IQ below 80 (Cohen & Harvey, 2016). Thus, there is nothing unusual about the Thurgau development of starting with a treatment that did not consider intellectual disabilities and then later expanding provision.

The seven-step program

This and the following section provide a basic overview of the program. Examples of responsivity issues being addressed are elaborated as appropriate.

Box 1: The seven steps

Step 1.	Sexuality and development: What I know about sex
Step 2.	Boundaries of sexual behaviour: The green and the red zone
Step 3.	Why have I sexually offended? A model for gaining insights
Step 4.	The consequences of my sexual offence for myself and others
Step 5.	Protection & control plan: This is how I can keep myself 'in the green zone'
Step 6.	Social and personal competences: Things I can do and things I am good at

nal of Intellectual Disabilities and Offending Behav

Step 7.	Revisions to the protection & control plan: Now I know how!

As part of **step 1**, participants learn to distinguish between sexual and non-sexual feelings and actions. A visual tool used is the 'relationship timeline' – a series of 31 photos, which display different behaviours that occur as part of a relationship, from meeting someone for the first time to arranging the first date, having sex, through to splitting up. Participants work together to bring these into the order in which they are likely to occur. Discussion topics include the notion of intimacy developing over time and the importance of building a trusting relationship between equals (thus not with children), as well as checking for reciprocity. **Step 2** introduces a traffic light system to distinguish acceptable sexual behaviours (green), from risky (orange) and unacceptable ones (red). Examples of its use are discussed shortly. **Step 3** uses the four steps in Finkelhor's (1984) precondition model to enables participants to gain insight into their own offending behaviours. How this works is described in detail elsewhere (e.g. Lindsay, 2009, p. 73ff:73ff). Here, it suffices to observe that step 3 enables the men to come to the realisation that they had systematically planned and executed their offences and that they have agency to stop this from happening again. **Step 4** looks at the consequences of participant's sexual offences for themselves and others.

Before treatment commences a 'protection & control plan' is developed for each participant. This is updated throughout treatment as therapists and patients become more familiar with a person's risks and triggers. **Step 5** gives participants the space to focus exclusively on refining their plan. For instance, Mr. A's plan itemises seven risky scenarios. The first one (reproduced in box 2) is becoming bored during unstructured leisure time. Finding things to do and engage will offer meaningful distraction from thinking about, planning and acting out sexually deviant acts (Lindsay, 2009). Mr. A is advised to take control of the situation by trying the activities listed in the second column. This includes watching a DVD. The 'external control' section summarises supervision arrangements that need to be in place for Mr. A to exercise his 'self-control' strategy safely. This patient has a sexual preference for pre-pubescent boys and he should therefore be guided to watch films that do not have young boys amongst the main cast, as such images may trigger sexual phantasies. If Mr. A did nonetheless find some of the content difficult he should be able to discuss this with a member of his support staff.

Box 2: Mr. A's protection & control plan (extract)

Risk – Situation *When do I need to take care?*	**Self-control** *What can **I** do?*	**External control** *(who? what? how?)*

Journal of Intellectual Disabilities and Offending Behav

In my leisure time When I'm bored	Listen to music, watch a DVD, talk about films, sport, go for a walk; Find something to do, projects (bake a cake, invitations) Participate in the group activities offered at my living group	Supervision: advise what films are suitable Discuss contents, assist in accessing sport activities Keep busy, support and supervise any projects

During **Step 6** participants assess their relationship competencies. They consider how they could improve the way they treat others and how such changes may help them to control their own sexual behaviours. Finally, the protection & control plan is refined further in **step 7**.

Most Forio treatment runs as open groups. This means that most participants will not work through these seven steps chronologically. There is also flexibility in the order in which topics are covered, as therapists can be responsive and react to what happens in the patient's lives. For instance, if a man reports that he has started a new relationship, the relationship timeline may be brought forward or recapped with reference to the new case study that was brought to group. However, every patient ends with the review of their 'protection & control' plan (step 7). Thus, when a patient is ready to complete treatment, this step may be inserted at any point and the whole group will support that patient to complete his final step.

Structure of the treatment sessions

Figure 1: Session structure

song	→	Reflective discussion round	→	7 step program tools (e.g. worksheets)	→	Feed-back	→	song	→	Farmer-riegel
Open		*Main part*				*Close*				*Farewell*

In line with the psychoanalytical tradition, treatment has a clear and predicable format (König, 2013, compare to figure 1). Firstly, the group is run regularly, weekly at the same time, in the same venue and format. Sessions last 75 minutes. They start and end promptly. The two therapists, one male, one female, remain consistent. Group sizes are four to five participants. Sessions are referred to as 'the course' and take place in a 'classroom' (see figure 2), which reinforces the notion of a learning environment. This approach is thought to be appropriate for the young men and less stigmatising than the use of offender or mental health terminology: The men are viewed as lacking skills that 'the course' can help them to acquire (Egli-Alge, 2010).

Journal of Intellectual Disabilities and Offending Behav

Figure 2: Group treatment room

Each session begins with the **treatment song**. One of the therapists plays the guitar and everyone, including therapists, joins in. The song has seven verses: Each verse summarises the key messages from one of the seven steps (see box 3). The idea that singing is beneficial as part of the course arises from empirical studies, including results from the PISA study, which demonstrated that children who sang in class, such as those from Finland, were much better able to memorise what they were learning than those who did not (Blank & Adamek, 2010; OECD, 2017). An example of similar uses in an adult education context is Anderson's (2006) description of the teaching methods of a law professor, who made their students repeatedly sing a complex legal rule. In spite of initial scepticism about this unconventional method, Anderson (2006, p. 129:129) was surprised to find that this enabled student's engagement with and learning of the rule, resulting in them still knowing the words to the rule two years later when they had to recall this information for their bar exam: 'After the bar exam, several members of the class admitted we had sung it to ourselves in order to answer the questions that required us to understand this long-winded rule.'

Forio aims for similar effects in the context of learning social rules. The rules here are, in line with the learning needs of the group, short and concise. One program architect asserts: 'If they sing "no sex with children", once at the start of class and once at the end, every week, over and over for two years, then they've sung it at least 200 times. And perhaps then it will sink in.' In other words, singing is thought to reinforce key messages through repetition. Singing furthermore promotes fast social bonding (Pearce, Launay, & Dunbar, 2015), which is of benefit to new members who have to

Journal of Intellectual Disabilities and Offending Behav

settle into the open group context. Singing has also been linked to confidence building in adults (Kleinerman, 2010). Thus, the treatment song has several uses.

Box 3: Treatment song chorus & verse 2 (extracts, translated)

We attend the course to take good care.
Every session we make a little progress.
In the end, we will reach step seven.

There are eight boundaries, that's important to me.
No means no and force is not allowed.
No sex with children, taking advantage is daft.

In the context of the wider evaluation study the second author of this paper visited the forensic outpatient service at the Charité hospital in Berlin, where Forio's 7-step program is implemented by Dr. med. Tatjana Voß[2] and her colleagues. Practitioners here reported they also sang, but their song was a 1970s pop song, which does not include any specific references to sexual offending. Nonetheless, therapists found singing beneficial. They notice that singing together as a group provides emotional security to group members: 'Everyone can sing, even the weakest member.' From their perspective, the song also functions to structure the session, by marking its start and end point.

The song is followed by the **'reflective discussion round'**. This utilises the most central visualisation of the treatment: a true to life sized traffic light lamp. It hangs immediately behind the therapists, visible to the patients (compare to figure 2). At the start of the session it is switched to green. The men reflect on their behaviours over the course of the past week with reference to the green (acceptable), orange (risky) and red (unacceptable) categories. For instance, Mr. B described that he had been angry with a member of staff. He swore and slammed the door. The group decided that this was aggressive behaviour and therapists changed the traffic light to red. It was discussed how else the problem could have been resolved. Therapists drew on advice from group members: What did they think should happen? Once Mr. B agreed to explore an alternative way of dealing with frustration, the situation was classed as de-escalated and the traffic light switched back to green. In other words, this is a way of clearly communicating what is and is not acceptable behaviour.

Next, the **7-step program tools**, such as the relationship timeline or worksheets about the program content described earlier, are used. After a closing **feedback** round treatment ends with

[2] Contact at: Tatjana.Voss@charite.de

Journal of Intellectual Disabilities and Offending Behav

the **song**. This is usually sung more enthusiastically than at the start. One therapist commented that this may be because there is a feeling that the work is now done, participants are proud of what they achieved and are looking forward to going home. At **farewell** participants receive a *Farmerriegel*, a popular brand of Swiss muesli bar, for their journey home. This is meant to serve as a token to reward engagement. In line with the aims of associative learning (e.g. Behrens, Hunt, Woolrich, & Rushworth, 2008) it also serves to remind participants of the treatment content in their daily lives by making an association between the taste of the *Farmerriegel* and the program.

The supervision and social care network

Many people with intellectual disabilities require input from their support systems to assist with risk management (Haaven & Schlank, 2001) and this is even more important for young (O'Callaghan, 2004). Consequently, Forio work closely with the supervision and social care network, which includes the referrer (generally the prosecution service), parents or other family carers, key workers (for instance, from the group home or sheltered workplace), therapists, as well as any further persons who are involved in planning and delivering supervision or care to the individual. The network make recommendations on personalising treatment, jointly monitor progress, help to reinforce lessons learned and support individuals in putting these into practice and in identifying potentially risky situations. They will also work to ensure that community sentence requirements are met. The network meets before treatment commences and then at regular intervals throughout. The frequency of these meetings is determined on a case-by-case basis and varies between monthly and every 6-8 months. Meetings are furthermore arranged ad hoc in response to major issues, such as a breach of community sentence requirements. Regular contact within the network is maintained via e-mails and phone calls and information shared whenever this is deemed necessary.

For instance, in the case of Mr. B, whose recollection of an incident of verbal aggression towards a member of staff was discussed earlier, a therapist called his living group after the session, to update staff on the new ways of dealing with anger Mr. B has agreed to try over the next few weeks and to ask them to support that effort. This illustrates that the network has a key role to play in supporting individuals to make immediate changes in their daily life. The 'protection & control plan' serves as a central reference point, which is continually updated. It ensures that the network is kept up to date on the risks a person identified for himself, which self-management strategies they aim to employ and what further supervision requirements remain.

After treatment completion participants and their network are offered aftercare in the form of risk-circles. These are not to be confused with circles of support and accountability (e.g. Wilson, Cortoni, & McWhinnie, 2009). The Forio risk-circles are principally a continuation of an active

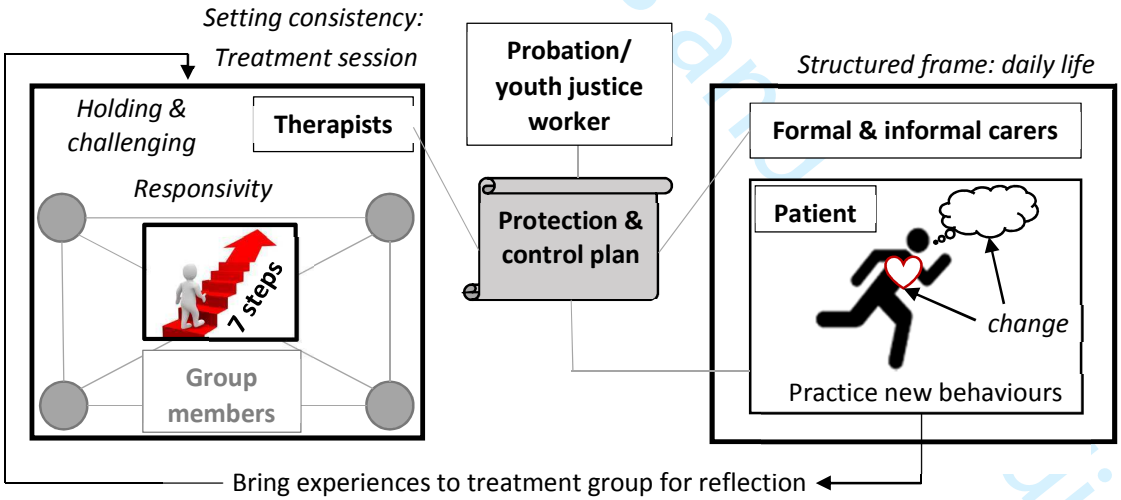
Journal of Intellectual Disabilities and Offending Behav

information exchange between all members of the supervision and social care network. The standard format is to offer this for one year after treatment and to hold meetings every three months, but practice varies and the same flexibility that was observed during treatment remains in terms of ad hoc meetings and exchanging information when required. Risk-cycles can furthermore be extended if a need for continuation is identified. Central to risk-cycle discussions is the transfer of lead risk management responsibilities from the Forio therapists to the key institution that is involved in the daily delivery of care. Risk-cycles furthermore help the patient, in that they re-emphasise the importance of up keeping their new behaviours by providing regular feedback and encouragement.

Discussion: Re-learning behaviour through daily practice

For many participants attending treatment is one of their community sentence requirements. In such situations, the 'protection & control plan' becomes legally binding. As illustrated in figure 3, it becomes the central reference point for the patient and their network, including therapists, the probation worker and any formal and informal carers. Throughout therapy the plan is reviewed and altered, as therapists (and patients) become more familiar with the individual's risks and new risk management strategies are developed and tested.

Figure 3: Key elements of the Forio program



A 'holding & challenging' treatment environment is created, and this is transferred to daily life, as therapists guide the supervision & social care network on means of enforcing structure, to ensure that risks are managed. Figure 3 illustrates this by placing two structured frames by either side of the

'protection & control plan': That of the treatment session (left) and daily life (right). Structure in group includes a clear and predicable format of the session and therapist consistency. Moreover, for the duration of treatment Forio expect patients to be placed in a controlled environment where they are supported to practice their newly learned behaviours. This could be a formal care environment or living at home with parents or foster carers. Crucial is that Forio can have a direct dialogue with key persons in the support network and that those key persons are committed to enforcing the 'protection & control plan'. This makes it possible to guide patients through challenges that arise in their daily lives, even including starting up new romantic relationships, as and when such opportunities arise. This daily practice of newly learned skills is key to treatment, as the feedback loop in figure 3 indicates: Subsequent reflections within group are key methods through which lessons learned are intended to manifest themselves.

At the core of the group session is the seven-step program. The way in which these steps are delivered is determined by responsivity issues. This includes the applied 'learning by doing' nature of the treatment, as well as appealing to a range of learning channels by use of song, visual objects, active participation in kinaesthetic tasks and role play. Change is intended to manifest itself in two ways: First, at the cognitive level participants learn about social rules and acceptable behaviour. These messages are reinforced through the song. Patients learn to know their own risks and coping strategies for dealing with them. Second, the men are also expected to change 'from within' (Haaven, 2006, p. 85:85), illustrated in the shape of a heart in figure 3. This manifests itself in a genuine motivation to work on oneself to stay offence-free. This motivation is encouraged by the complex interplay between several factors. The holding environment and modelling of positive relationships within the treatment session, as well as enhanced wellbeing and the building of a good life are key, as this enables participants to become willing to change (Lindsay, Ward, Morgan, & Wilson, 2007).

An additional influence in treatment are group processes. Due to limited space, the focus here was on therapist's actions to run the group, rather than on interactions between group members. What we have seen is that Forio therapists aim for a supportive, non-threatening leadership style and they encourage participants to interact in a supportive manner (William L. Marshall & Burton, 2010). Examples discussed were therapists inviting patients to collaboratively problem-solve and involving group members in role play to explain complex issues to one another. Structured activities, such as the 'relationship timeline' rely on interactions between participants. When a group member is ready to finish treatment, the whole group will support him through discussions to complete step 7: The final refinement of their protection & control plan. This is in turn a valuable learning experience for those who are at an earlier stage in therapy, as it indicates to

Journal of Intellectual Disabilities and Offending Behav

them the work that lies ahead. In figure 3 the relationship between patients is illustrated by them building a support network around the '7 step program'. In other words, they are encouraging each other to take these steps together.

Implications for practice

This paper outlined a Swiss group program for juveniles and young men with intellectual disabilities who have sexually offended. Even though terminology and rationales differ, the international reader was able to recognise many similarities to comparable programs in respect to program objectives and the way responsivity is approached (a full international comparison is presented in *[author's own]*). The least conventional tool used is the treatment song. Several benefits have been discussed, including its use in enabling participants to memorise social rules, but also its effect on confidence building and bonding. It would be interesting to explore whether and how this method could be used outside the German-speaking regions.

Linking with community care providers is also described for other community based programmes known internationally (e.g. Rose, Rose, Hawkins, & Anderson, 2012), but the work done by Forio is most comprehensive. The Swiss context offers comparatively more freedom to practitioners to design personalised interventions and these will be described in more detail with reference to case studies in future publications. The centre-staging of the control plan as one reference point for all external agencies, including the probation worker, family carers and key workers from residential, workplace or leisure settings works well. In the context of continued inconclusive evidence on the long-term effectiveness of treatment, the Forio commitment to longer-term aftercare and risk monitoring could work as a model to evidence longer-term impacts, as well as give rise to opportunities for preventative interventions when risks increase. Regular clinical guidance offered by therapists to social care teams could also be an option for participants who have completed treatment in hospital or prison and whose risks remain high post-treatment.

References

Anderson, L. S. (2006). Incorporating Adult Learning Theory into Law School Classrooms: Small Steps Leading to Large Results. *Appalachian Law Journal, 5*, 127-149.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*, 19-52.

Ayland, L., & West, B. (2006). The Good Way model: A strengths-based approach for working with young people, especially those with intellectual difficulties, who have sexually abusive behaviour. *Journal of Sexual Aggression, 12*(2), 189-201.

Behrens, T. E. J., Hunt, L. T., Woolrich, M. W., & Rushworth, M. F. S. (2008). Associative learning of social value. *Nature, 456*(7219), 245-249.

Journal of Intellectual Disabilities and Offending Behav

BFS. (2012). Statistik der sozialmedizinischen Institutionen: Die Situation der Menschen mit Behinderung in sozialen Einrichtungen. Retrieved from https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/gesundheitswesen/spezialisierte-institutionen.assetdetail.348704.html

Blank, T., & Adamek, K. (2010). *Singen in der Kindheit*. Münster: Waxmann Verlag.

Bullens, R. (1993). Ambulante Behandlung von Sexualdelinquenten innerhalb eines gerichtlich verpflichtenden Rahmens. *Inzest und sexueller Missbrauch*, 397-412.

Bullens, R. (1994). Faktoren der Behandlung von Sexualstraftätern. Motive, Therapiesetting, Nachsorge. *Forensische Psychiatrie und Psychotherapie. Werkstattschriften., S*, 33-53.

Cohen, G., & Harvey, J. (2016). The use of psychological interventions for adult male sex offenders with a learning disability: a systematic review. *Journal of Sexual Aggression, 22*(2), 206-223.

Dobson, K. S., & Dozios, D. J. A. (2010). Historical and philosophical bases of the cognitive-behavioral therapies. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 3-38). New York: Guilford Press.

Egli-Alge, M. (2010). Behandlung minderbegabter junger Sexualstraftäter. In P. Briken, A. Spehr, G. Romer, & W. Berner (Eds.), *Sexuell grenzverletzende Kinder und Jugendliche* (pp. 210-224). Berlin: Pabst Science Publishers.

Finkelhor, D. (1984). *Child sexual abuse : new theory and research*. London: Free Press.

Fischer, H., & Renner, M. (2015). *Heilpädagogik: Heilpädagogische Handlungskonzepte in der Praxis* (2nd Ed.). Freiburg im Breisgau: Lambertus-Verlag.

Foucault, M. (1977). *Discipline and punish : the birth of the prison*. London: Allen Lane.

Haaven, J. L. (2006). Suggested treatment outline using the Old Me/New Me model. In G. D. Blasingame (Ed.), *Practical treatment strategies for persons with intellectual disabilities: Working with forensic clients with severe and sexual behavior problems* (pp. 85-114).

Haaven, J. L., Little, R., & Petre-Miller, D. (1990). *Treating intellectually disabled sex offenders: A model residential programme*. Orwell, V.T.: Safer Society Press.

Haaven, J. L., & Schlank, A. (2001). The challenge of treating the sex offender with developmental disabilities. *The sexual predator, 2*, 13.11-13.19.

Helfferich, C. (2011). *Die Qualität qualitativer Daten: Manual für die Durchführung qualitativer Interviews* (4th ed.). Wiesbaden: VS Verlag.

Jones, E., & Chaplin, E. (2017). A systematic review of the effectiveness of psychological approaches in the treatment of sex offenders with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*. doi:doi.org/10.1111/jar.12345

Kleinerman, K. (2010). Singing for leadership: Fostering the development of female leaders through voice. *Advancing Women in Leadership, 30*, 1.

König, K. (2013). *Abstinenz, Neutralität und Transparenz in psychoanalytisch orientierten Therapien*. Stuttgart: Klett-Cotta.

Lindsay, W. R. (2009). *The treatment of sex offenders with developmental disabilities: a practice workbook*. Chichester: Wiley-Blackwell.

Lindsay, W. R., Ward, T., Morgan, T., & Wilson, I. (2007). Self-regulation of sex offending, future pathways and the Good Lives Model: Applications and problems. *Journal of Sexual Aggression, 13*(1), 37-50.

Manzano, A. (2016). The craft of interviewing in realist evaluation. *Evaluation, 22*(3), 342-360.

Marotta, P. L. (2017). A Systematic Review of Behavioral Health Interventions for Sex Offenders With Intellectual Disabilities. *Sexual Abuse: A Journal of Research and Treatment, 29*(2), 148-185. doi:10.1177/1079063215569546

Marshall, W. L., & Burton, D. L. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior, 15*(2), 141-149.

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2011). *Rehabilitating sexual offenders: A strength-based approach*. Washington, DC: American Psychological Association.

Journal of Intellectual Disabilities and Offending Behav

O'Callaghan, D. (2004). Adolescents with intellectual disabilities who sexually harm: Intervention design and implementation. In G. O'Reilly, W. L. Marshall, A. Carr, & R. C. Beckett (Eds.), *The Handbook of Clinical Intervention with Young People who Sexually Abuse* (pp. 345-368): Psychology Press.

OECD. (2017). The Programme for International Student Assessment (PISA). Retrieved from http://www.oecd.org/pisa/

Pearce, E., Launay, J., & Dunbar, R. I. (2015). The ice-breaker effect: singing mediates fast social bonding. *Open Science, 2*(10), 150221.

Rose, J., Rose, D., Hawkins, C., & Anderson, C. (2012). A sex offender treatment group for men with intellectual disabilities in a community setting. *The British Journal of Forensic Practice, 14*(1), 21-28.

Schmelzle, M. (2015). Grundhaltung und Behandlungsansätze in der psychotherapeutischen Arbeit mit Jugendlichen, die sexuelle Übergriffe begangen haben. *Kindesmishandlung und -vernachlässigung, 18*(2), 158-177.

Watt, S., & Scott-Jones, J. (2010). Let's look inside: Doing participant observation. In J. Scott-Jones & S. Watt (Eds.), *Ethnography in social science practice* (pp. 107-125). London: Routledge.

Wilson, R. J., Cortoni, F., & McWhinnie, A. J. (2009). Circles of Support & Accountability: A Canadian National Replication of Outcome Findings. *Sexual Abuse: A Journal of Research and Treatment, 21*(4), 412-430.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*: Hogarth Press London.

nal of Intellectual Disabilities and Offending Behav