British Journal of Social Work (2020) **0**, 1–20
doi: 10.1093/bjsw/bcaa038

Successful Community Resettlement of Men with Learning Disabilities Who Have Completed a Hospital-Based Treatment for Sexual Offending

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Abstract

Treatment for sexual offending equips men with learning disabilities with tools required for pro-social community living. In the past, risk aversiveness prevented discharges from hospital, but fieldwork took place at the time of the Transforming Care Agenda, which sought to enable more people to return to their communities. This offered the opportunity to gain unique insights into community resettlement planning in cases that require ongoing risk management. Eleven case studies were examined through qualitative interviews with the men and professionals. A realist evaluation methodology was applied to examine how treatment outcomes manifested longer term. It was evidenced that treatment had equipped men with risk management tools, as well as encouraged them to develop realistic visions for their pro-social futures and that both outcomes come to fruition under conditions that allow positive risk taking. The welfareist and user-led nature of working towards pro-social community living makes this a useful toolkit for social work, whilst input from forensic health services was valued for skilling up the social care workforce. However, discharge practices continued to be influenced by contextual factors, including local availability of resources and personal attributes, such as men's sexual preferences and levels of compliance and some men remained in hospital.

Keywords: adapted sex offender treatment, forensic social care, harmful sexual behaviour, hospital discharge, intellectual disability, learning disabilities

Accepted: March 2020

Introduction

This article explains how treatment for sexual offending facilitated community resettlement planning for men with learning disabilities who had remaining risks. At first, an overview of the policy context is presented. This is followed by a brief description of the treatment.

The drive towards a reduction of institutionalised resources

Secure psychiatric hospitals 'are a high-cost, low volume service consuming around a fifth of the overall mental health budget in England and Wales', with costs ranging from £152,000/year per patient in low secure and £273,000 in high secure services (Fazel *et al.*, 2016, p. 17). In England, around 12% of psychiatric inpatient beds are occupied by the 2,185 people with learning disabilities receiving care commissioned by the National Health Service (NHS) (The Strategy Unit, 2019; NHS Digital, 2020). The aim of their hospital stay is to access specialist mental health services intended to reduce harmful behaviours and to aide recovery from past trauma. However, in 2011, institutional abuse was revealed at Winterbourne View, a specialist hospital for people with learning disabilities (BBC Panorama, 2011). In response, the Transforming Care agenda was launched. This assumed that long-term hospitalisation has adverse effects on quality of life and care and that both will improve upon community discharge (NHS England, Local Government Association and Association of Directors of Adult Social Services, 2015; NHS England, 2017, 2018). Transforming Care aimed to reduce the number of inpatients with learning disabilities by 35–50% within three years and by March 2019.

Heenan and Birrell (2018, p. 1743) point out that 'hospital discharge is not a single or isolated event but [it] is rather a complex series of linked incremental steps that involves a wide range of groups and networks sharing knowledge and making decisions'. Discharge practices are thus shaped by social and legal contexts. In addition, 53% of inpatients in secure setting have offending histories (Fazel *et al.*, 2016). The transforming care documents make limited reference to how these issues may affect discharge planning, but professionals understand that remaining risks are key stumbling blocks when it comes to community resettlement planning (Hollomotz, in press; Hollomotz and Talbot, 2018), which is why this article sheds light on how these can be managed.

Treatment for men who have sexually offended

Modern programmes for men with learning disabilities who have sexually offended are underpinned by a theory of positive psychology.

They thus encourage individuals to strive towards a better, offence-free future (Griffiths *et al.*, 1989; Haaven *et al.*, 1990). In contrast to traditional relapse prevention strategies, this way of working impacts positively on men's sense of self-control: 'They are seeking to become something, rather than just trying to avoid doing something' (Haaven, 2006, p. 77). According to the Good Lives Model 'individuals commit criminal offences because they lack the opportunities and/or the capabilities to realise valued outcomes in socially acceptable ways' (Lindsay *et al.*, 2007, p. 48). In other words, 'assisting individuals to achieve goods via non-offending methods may function to eliminate or reduce the need for offending' (Ward and Maruna, 2007, p. 108). This welfareist approach and its potential to give the user some control, even leadership, in their future planning makes this an appealing tool for social work, as this is in line with the principles of promoting best interest decisions, supporting people's rights to make their own choices and promoting empowerment (British Association of Social Workers, 2014).

As this article focuses on a sample of men post-treatment for sexual offending, it is imperative to have an appreciation of the two intended treatment outcomes, which are as follows: First, the aim is to increase risk management capacities. This is done through sex and relationship education, which encourages participants to distinguish the boundaries of sexual behaviour. Men achieve insight that their offences did not 'just happen'. They learn to identify their own risks and triggers. Men also learn (sexual) self-regulation. Secondly, the aim is to encourage the development of pro-social identities through taking on meaningful social roles, the formation of positive relationships and promoting pro-social personal values (for more detail, see Hollomotz and Greenhalgh, 2019). The two objectives of risk management and identity development are intertwined, as it has long been acknowledged that, in order to change participant's behaviours for good, treatment needs to move beyond punishment and engage men in ways that are meaningful to them (Prescott and Levenson, 2010).

Post-treatment most people with learning disabilities need external support with risk management 'through monitoring and assistance in high risk situations' (Haaven, 2006, p. 75). Requiring help does not mean that treatment has 'failed' if the risks have become manageable. External support could be delivered through 24/7 supervision or less intensive community support packages. Staff will be trained on a person's risks and triggers, ready to direct them away from risky situations. This article provides several examples on how this is done.

Methods

This article arises from a realist evaluation of treatment programmes for men with learning disabilities who have sexually offended. The focus

here is on explaining how treatment's intended outcomes are helped to manifest during community resettlement. This section provides details about the realist evaluation methodology, the research site and sample, on data collection and data analysis.

Realist evaluation methodology

Realist evaluation is a methodological strategy for evaluating complex social programmes (Pawson and Tilley, 1997). Kazi (2003) believes that it is suited for evaluating social work practice as it recognises that the world is an open system. Realists understand that programme outcomes, such as successful risk management following sex offending treatment, cannot be explained in isolation. Rather, programmes offer resources to participants (an example discussed later will be risk diaries) and it is how participants respond to these, in terms of changes in their reasoning and behaviour (known as 'mechanisms') that bring about change. Mechanisms are 'deeper', usually non-observable processes, which generate the observed relationship between intervention and outcomes (Dalkin *et al.*, 2015). Mechanisms then 'effect change in a constellation of other mechanisms and structures, embedded in the context of pre-existing historical, economic, cultural, social and other conditions' (Kazi, 2003, p. 805). More detailed explanations are provided shortly under data analysis. For now, it suffices to say that the realist evaluation methodology guided decisions on sampling, methods and analysis.

The sample

The hospital where this research took place has medium, low secure and step-down services for people with learning disabilities. It was used as a flagship fast track site of the transforming care agenda (NHS England Local Government Association and Association of Directors of Adult Social Services, 2015). Treatment groups for men with learning disabilities who have sexually offended were running between 2006 and 2017, treating altogether thirty-three men to successful completion in six cohort groups. After reviewing the thirty-three patient files a sample of eleven men were selected by the researcher and therapy team for case study research. The aim was to explore a spread of cases at various points of their discharge journey. Table 1 provides some basic information about them. Note that patient's names are pseudonyms and the first letter of their name indicates their discharge status at the time of their interview.

Four patients had been discharged. Three were in transition and four had no active discharge plans in place ('stagnant'). Two of those were in

Table 1. Overview of the case studies.

Name	Discharge status	Age group	Years spent in hospital	Victim population	MHA section[a]
Mark	Moved out	50–59	10–14	Children	37/41
Marvin	Moved out	20–29	5–9	Children	47
Matthew	Moved out	40–49	5–9	Children	37/41
Michael	Moved out	20–29	<5	Children	37
Tim	In transition	50–59	10–14	Children	37/41
Tony	In transition	60+	20+	Children	37/41
Travis	In transition	50–59	20+	Children & vulnerable adults	37/41
Sasha	'stagnant'—step down	30–39	10–14	Children	37/41
Simon	'stagnant'—step down	20–29	5–9	Vulnerable adults	37/41
Sean	'stagnant'—low secure	30–39	15–19	Vulnerable adults	3
Stuart	'stagnant'—medium secure	50–59	30+	Female care staff	3

[a]Mental Health Act 1983 sections brief overview:
Section 37—Hospital order; Section 37/41—Hospital order given by Crown Court, Section 47—Transfer of a sentenced prisoner to hospital (for more information, see Rething Mental Illness, 2020b); Section 3—Treatment order (Rething Mental Illness, 2020a).

the step-down service, one in the low and one in the medium secure service. A spread of age groups was represented. Patients had spent between 4½ (Michael) and almost forty years (Stuart) in hospital. Eight of the eleven patients had offended towards children and all but two were held in hospital on criminal sections of the Mental Health Act (HMSO, 1983).

The interviews

Sociological disability research favours methods that involve disabled people in the research process. For instance, Walmsley and Johnson (2003) established several distinguishing features of inclusive research, including that the research problem should be owned by disabled people. This requires disabled people to play a significant role in phrasing the research problem, in conducting the research and disseminating the findings, which is not the case in this project. In line with Walmsley and Johnson's (2003) recommendations, it was however conducted to further the interests of disabled people and to address issues which matter to them. It also aimed to access and represent their views and experiences, involving men with learning disabilities who have sexually offended in qualitative interviews as equal informants alongside professionals. The men were given some control over how their case would be researched, as outlined shortly.

Hollomotz (2014) highlighted that few studies had taken the most basic first step towards involving people with learning disabilities who have

sexually offended in research by failing to engage them as primary informants, although this is now slowly changing (e.g. Chester *et al.*, 2019; Melvin *et al.*, 2019). Hence, although this is not an inclusive study, it has nonetheless made a bold move by accessing the views of a group who are rarely directly involved as informants. Interviews with the men lasted between 30 and 60 min. They took place either at the hospital or in men's new homes. Questions enquired about experiences of treatment, relationships with staff and peers, risk management, subjective life satisfaction and ambitions for the future.

Interviews were held in plain language and utilised techniques for enabling accessibility as described by Hollomotz (2018). This included adjusting the depth of questioning to the response style of participants. Questions were relevant to respondent's experiences, relatively direct and specific. At the end of each interview, men were asked to draw their social network on flipchart paper. Individuals within the network were drawn on post-its and this enable them to be repositioned as men discussed them. Proximity to the men at the centre of the drawing indicated importance of the relationship. This exercise was used to identify individuals whom the researcher would speak to further about each patient. Although family members were mostly included in the drawing, none of the patients felt comfortable to have them participate in the study.

As a result, altogether twenty-two professionals were interviewed. Half worked at the hospital. This included two forensic support services workers, learning disability nurses who specialised in supporting patients who had resettled or were in the process of resettling into the community. They would train community support teams and offer advice if a patient was struggling with community living. There were five case managers (learning disability nurses), one ward-based care worker, one therapist and two responsible clinicians. This is the mental health professionals in charge of a person's care and treatment while they are sectioned under the Mental Health Act (HMSO, 1983). One was a psychologist and one an advanced nurse practitioner. The eleven community-based professionals comprised one community services manager, two social workers, four care workers, on solicitor and two community learning disability nurses.

Interviews with professionals asked further questions about patient's progress in treatment, journey through the care pathways and the discharge process (if applicable), their risk management capabilities, legal issues and social care support. These interviews were also an opportunity to follow up on issues the men could not fully explain. Many times, a patient would state in his interview that they could not recall a specific issue, for instance why there was a delay in discharge, and they referred to a person from within their care team who could explain. Each patient was discussed by two to five professionals. Eight professionals commented on more than one patient. At times, this happened within one

interview. For instance, one responsible clinician discussed altogether four cases in one interview that lasted seventy-five minutes. The solicitor discussed two cases in one forty-five minute interview. Other interviews were done separately. For instance, one case manager wanted to discuss Tony and Sasha on separate days as she felt the interview would otherwise be too lengthy. These interviews were approximately thirty-five minutes each. Overall, interviews with professionals lasted from thirty to seventy-five minutes.

The study received ethics approval from the NHS Health Research Authority (REC reference number 15/LO/1217).

Data analysis

The author read and re-read the transcripts and thematically analysed these across cases to identify similarities and differences in the resource–mechanism outcome configurations. Following several iterations, they disentangled how mechanisms operated and outcomes manifested and how these processes were at times facilitated and at times hindered by contextual factors. For instance, it will be shown how the risk diary encourages self-monitoring and promotes an open dialogue between staff and service users. However, openness is influenced by an individual's levels of compliance. Amongst others, self-monitoring requirements are determined by a person's sexual preference. All these resources, mechanisms and contexts constantly interact, and constellations need to be right to achieve the intended outcome of successful risk management. The intention in this article is to deploy realist analysis to provide useful insights to practitioner readers on the mechanisms that help to upkeep the intended treatment outcomes upon community resettlement and thus help to drive better social work practice. It will also highlight how practice needs to be adapted in response to contextual factors.

Findings

Treatment for men with learning disabilities who have sexually offended does not provide a 'cure' in the conventional sense. For instance, it cannot 'cure' a sexual preference for children, but it can enable the individual and those around him to understand his risks and to develop risk management strategies. As such, treatment becomes a new way of living one's life, as one responsible clinician explains:

> 'Treatment never finishes. I say to them: 'What we need to look at now is: How do you use treatment in terms of how you live your life? How do you make that part of how you are, who you are and what you do?'

This article explores how treatment outcomes can manifest when men access or move to the community. The findings are divided into two sections, each focussing on one key outcome: risk management and prosocial lives.

Risk management

In an earlier article that described the sexual offending treatment at the hospital where this research took place McNair *et al.* (2010) reported that only two of the ten men from the first two completed treatment cohorts had been resettled into the community. Several others were ready for discharge but did not have an active discharge plan in place. One of the therapists commented during the first phase of this project in 2015 (reported by Hollomotz and Greenhalgh, 2019):

> People are reluctant to take them, because of stigma, prejudice, or they haven't got the service, the money, whatever... The men work so hard for so long, but then nothing changes. [...] It makes it look like the group doesn't work. [...] Then they end up with problems, with anger and aggression, because they are stuck here.

There seemed to be fewer of these cases during the phase of data collection reported on in this article (2017). The professionals agreed that there was now more willingness to take up discharge planning for people with remaining risks. One responsible clinician explained:

> There has been a shift to peoples' perception of what constitutes being ready for discharge. Historically, it meant being fully incident-free, complying with all your treatment, demonstrating your ability to understand your risks, manage your risks. The bar has shifted, because that is not realistic for most people.

Travis, Tony, Tim and Mark are long-stay patients with between thirteen and twenty-three years spent in hospital, who have benefitted. A forensic support worker explains: 'Historically, there was never any real drive to get people out of hospital who were high-risk'. Other authors, such as Turner (2019) confirm that careful planning around individual needs has enabled recent discharges of individuals for whom community living had been 'unthinkable' only a few years earlier. The other responsible clinician further explains:

> It's a case of: Can the risk people pose be mitigated? For Sasha the risk is mitigated by the strategies he has learnt through treatment and his insight into having this risk fully mitigated by having staff around him.

> Individuals whose risk cannot be mitigated by relational support, who are at risk of absconding, they need to be in secure settings.

She believes that all men who have completed the sexual offending treatment should be manageable in the community: 'Treatment is giving people tools to mitigate their risks, either fully themselves or by others'. To what extent they can do this is tested through unescorted ground leave and escorted community outings. Gradually patients gain trust and work towards unescorted community access (a walk into the nearby village). Sean's solicitor was frustrated, as his unescorted ground leave had stopped following an adult safeguarding allegation. She argued that Sean's team must work towards reinstating ground leave, as without she will be unable to make a convincing case that Sean is safe to discharge.

One key resource that was introduced by treatment is the risk diary. This can be drawn or written or both. Michael explains:

> You do a diary sheet before you go out, what will you see. [...] And then you come back, do a diary sheet, if there were nothing, no risks, nothing, there was no thoughts. Or if there was you could put it down and talk to staff.

The diary is thus both, predictive and reflective. The aims are to encourage self-monitoring, develop problem-solving skills, reinforce learning from group and develop openness (Hordell *et al.*, 2008). One experienced forensic community service provider required all completers of the programme to regularly use their diaries upon discharge, even if they had stopped using these previously, as these encourage dialogue between men and staff. To assist with the export of treatment tools from hospital to community settings men who were preparing for discharge reportetly responded well to refresher sessions with the forensic support service.

Tim explains what he does to manage risks: 'When I'm out there if I see a little person, I tell my staff about it. When we move away from a shop, that's just me taking responsibility. When I see a little person, my head starts wandering'. Note that Tim does not deny that he struggles with thoughts. He is open about the need to manage these. Similarly, Sasha's responsible clinician comments: 'It's incredibly honest of him to say, "No, I'm still having these thoughts, I don't feel safe. If I haven't got staff with me, I'd have concerns about what would happen"'.

Many men carry personalised reminder cards on community outings. They are pocket sized, laminated and held together by a keyring. Sasha explains: 'I carry my cards. And when I go out, they're in the pocket and I tell the staff if you touch your pocket you know there's something wrong. Then they help me get out of there'. Mark explains further that his cards contain: 'No children and that lot, adult females, all that kind

of stuff. Prison, my family, my Xbox, drinking'. Some of these are risks to avoid, others are privileges he would lose if he reoffended. For care staff the reminder cards provide a useful overview of men's risks and personal motivators and they will refer to these when needed.

Tony's case manager explains how staff can support even patients with limited risk management abilities:

> When we're out in the community where there's children present, Tony will stare, and we've got to tell him not to. He'll carry on staring; his finger will go in his mouth, that's when he's anxious, and maybe having thoughts. [...] He hasn't got the capacity to process what we want him to do to manage his risks.

Nonetheless, Tony's compliance is considered enough to make external risk management possible. For instance, the case manager asserts: 'He listens to us every time'. Mark is a little trickier, because his compliance is not as reliable as Tony's. His community nurse explains: 'He's exceptionally manipulative. [...] If he was placed in the community with no support, he'd very quickly reoffend'. Nonetheless, the nurse has faith in the risk mitigation skills of Mark's current support team. This is not the case for Sasha. Note that Sasha was classed as 'stagnant'. Discharge planning was on hold, as he was waiting for a decision by the mental health tribunal. However, a future community service had been allocated, although a dwelling had not yet been identified. The new care team had taken Sasha on outings. The responsible clinician recalls an incident when they had taken Sasha to a horse-riding lesson. Sasha needs to leave promptly after his lesson to avoid contact with children. Despite these rules, the support staff allowed Sasha to remain in the stables caring for the horses: 'At some point you've got to step in and say, "No Sasha, this is it, this is your time, children coming in, that place is then at risk and you're at risk of offending, we're going"'. Due to incidents like this the responsible clinician has now put a stop to the provider taking Sasha off hospital grounds.

Unfortunately, no representative from this provider was interviewed, but it appears that they would benefit from additional input by the forensic support service. As previously mentioned, they train and support community teams. At times this engagement could re-start years after discharge. The solicitor explains: 'If the providers are saying: "He's not really doing the diary sheets" or whatever, they will come and visit and refresh the patients and talk to the staff'. Travis' service manager explained that the hands-on, practical help they offer is especially beneficial and that his staff team learn a lot from observing how this is done. For example: 'Travis was talking about going to the local hairdressers, so the nurse did a bit of roleplay. Stood behind him pretending he's

cutting his hair, started asking him all the questions that the hairdresser would ask'. This links to the next section, as it is about Travis presenting a pro-social identity in a social interaction, but it is also relevant to risk management, as Travis could potentially put himself at risk of retaliation by disclosing his offending history. The exercise enabled Travis to be prepared for personal questions and he developed a socially accepted narrative about his past. This was an account of recovery from mental illness, which omitted some details. The service manager believed that more input of this kind is needed. He suggested regular visits by the forensic support service scheduled for all service users with remaining risks could help to maintain the skills base of social care teams. Currently, the forensic service only has capacity to help during resettlement or when change or problems are reported.

Stuart has a history of sexual violence towards female staff. He is currently in the medium secure unit and professionals are unable to envision community discharge. Similarly, although Travis's index offences were against children, he accumulated a string of further safeguarding incidents involving grooming vulnerable adults within the hospital and these additional risks require further risk mitigation, which caused a significant delay to his discharge. Thus, for those who pose risks merely to children, it is possible to create community support packages that avoid contact with this group. In contrast, men who pose risks to adults need to be manageable in the presence of their victim population.

Pro-social lives

Matthew's case was upheld as the gold standard of successful resettlement by several of the hospital-based professionals. His therapist explains:

> He had a pretty dysfunctional family, bad relationships with them. [...] He is living very successfully in the community now. He can commute to work on his own. [...] He's got a job in a garage as a mechanic. He is doing his NVQs. He's seeing his mum every week. He goes to football. He goes to a night club, meeting women. He just developed a really good life in the community. [...] It wasn't about getting back to where he come from. It was about moving on and getting something better.

What this therapist hints at is that Matthew's return to the community needed to be carefully planned, to ensure that he would not return to his old ways of thinking and behaving.

Employment and unsupervised time are not achievable for all men or at least not so soon after discharge, but they may still achieve a fulfilling life. Travis was hospitalised for over twenty years. He completed treatment ten years ago and is only now preparing for discharge. He

currently spends five nights per week at his new community home. Travis reflects:

> I've got the right people. I've got united with my family. I've got a building which I'm going to be a tenant. I've been doing a lot of walking which I enjoy. [...] [It is] going to be my door once I get my keys, so that's an opportunity because I could risk open the door and leave the property, but I don't. To my mind, I want to be out there instead of here, and I want to keep out there and prove successful.

His new life in the community acts as a motivator to stay out of trouble for, as his forensic support services worker reflects:

> One of the motivators on a relapse prevention card, if you do good, then this will happen. It was all made up because they were all 'ifs'. But now it's happening. He's got a real life that, potentially, he could lose. Whereas if you were in an inpatient setting, what have you got to lose?

Men's personal motivators differ. Some value contact with family and want to make them proud. Others are motivated by a sense of belonging, like being part of a football club or neighbourhood. It could be having a job, volunteering, going to college or a romantic relationship. For Travis, the motivators are about having a place of his own. 'Homemaking' appeared important across cases. For instance, Marvin, who had moved to the community four years prior to the interview, could still recall the pride he felt at choosing his own furniture, down to the bed that would go in the carer's room.

Travis's community service manager explains some key considerations when it comes to designing social care services that incorporate supported risk management:

> It is all about creating an environment where they don't feel policed, they don't feel staff are on top of them all the time. They want to lead, which then goes back to everything about the good life model, I've built something up here that I don't want to lose, coupled by the fact that there are bits that I've learnt with therapy about what I need to do to stay safe.

This distinction between appearance and substance is interesting. The men are made to 'feel' in control whilst being restricted or monitored. Marvin's case manager provided an example of how Marvin enjoying 'freedom' results from detailed planning and covert supervision. Marvin is legally obliged to avoid contact with children under sixteen. This includes avoiding schools and playgrounds. The case manager explained how he planned Marvin's cycle route to the gym:

> I'd done the route at certain times of the day to see what kind of footfall is on the streets, the ages and the type of people that are around as part of a risk assessment. [...] We will also do some checks on Marvin. So, as he's cycling to the gym, one of us will park up somewhere and wait for him to cycle past to make sure he's sticking to the designated route.

Many of the men are supervised by the sex offender management unit (police), who determine what social care providers can do with the men. Michael's forensic support worker explains: 'The police put a stop to Michael doing some dog walking on a voluntary basis. They thought it was a risky activity and he may try to groom children, even though Michael would be with a member of staff'. Travis was faced with the same restriction. He demonstrated resilience by turning the ban on dog-ownership into a personal motivator: 'Basically, when I'm settled, and I get the trust maybe I will get a dog'. Thus, he plans to display good conduct to gain trust.

Disappointingly, Marvin never ended up cycling to the gym. The case manager explains:

> The police said that fourteen-year olds can attend the adult-only gym. We said, 'If he goes during school hours, then the minors should be at school.' They said, 'That's not good enough.' We said, 'We'll send staff with him.' The police said, 'That's good enough. What we'll do now is we'll inform the gym that Marvin is a sex offender.' I gave the choice and Marvin chose to cancel his membership.

Achieving a fulfilling life becomes challenging under given restrictions and it takes much creative thinking on part of the social care team to fill the void that the disappointment over such missed activities has left. Marvin now goes on lengthy cycle rides in rural areas. 'He likes cycling, and we've got quite a few staff who like cycling as well, so we put them on shifts'. Yet, this option offers less opportunity for social interaction.

Whilst at the hospital, the men idealised their lives post discharge, but once outside it became apparent that they missed some of their previous routines and contacts. In hospital, individuals had participated in a range of activities, such as gardening, arts and crafts and various volunteering opportunities. Over the years, some meaningful relationships developed. Many of the men had a sense of community and in several ways: Being part of their therapy group, their flat or other activity-based groups. Losing these ties is what the hospital-based professionals linked to Michael breaching his bail conditions within weeks of discharge. He had used an unregistered electronic device, and it was suspected that he had used this to access illegal images of children. The device was confiscated

by the police for further investigation. The former ward-based case manager asserts:

> The key to keeping Michael and others safe is for Michael to be busy. [...] He was so active while he was here, so to go to a house where he's literally shopping, walking, doing bits of cycling. There should have been other things in place to keep him busy. [...] That's what we get wrong for people. When they move out into the community, that busyness and activity should double, but it doesn't.

Note that Michael's levels of activity were comparable to Travis', but the difference is that Travis was content. The community service manager linked this to their age, Michael being around thirty years younger than Travis.

Discussion

This article focusses on successes and is thus biased towards presenting mostly data that demonstrates how obstacles in community resettlement planning can be overcome. There is additional literature, which discusses persistent problems, for example, the limited impact that Transforming Care had nationwide on discharge practices and on the expansion of community services (e.g. Barnoux, 2019; Taylor, 2019). Moreover, due to limited space this article could not cover all relevant contextual conditions. For instance, a separate paper is required to make full sense of the law. It is notable that the two patients who had no criminal convictions (held on Section 3 of the Mental Health Act) had no active discharge plans in place. Questions could be posed on whether Section 3 applies less pressure on patients to be discharged, whether discharge pathways are less well developed or whether the needs of patients with sex offending histories on this section tend to be more complex.

Securing dwellings and becoming registered with a responsible clinician in the community caused considerable delays and these have not been discussed. Furthermore, two of the eleven men had autism alongside learning disabilities. Three had personality disorders. These men needed additional accommodations during treatment and resettlement, but there was no space to explain these. Risk assessments carried out by social care were at times overruled by the police, which created challenges for planning meaningful activities towards pro-social living. Solutions for interagency working across health, social care and criminal justice were discussed by Hollomotz (in press) and Hollomotz and Talbot (2018), but this article could have been further strengthened by including the police perspective on the case studies.

These limitations aside, the findings offered detailed insights into the contexts that impact on community resettlement planning post treatment. First, the concept of discharge readiness differs throughout time. A decade ago, most completers of the treatment were considered unsuitable, due to the ongoing risks they carried and lack of means to manage these. However, at the time of fieldwork, the policy drivers to reduce hospital stays meant that, at least at the research location, remaining risk post treatment could no longer be assumed to be an insurmountable obstacle. Instead, renewed efforts went into finding ways to manage risk. However, being 'discharge ready' on its own was not enough. The availability of local resources, including a suitable social care service, was essential. Moreover, legal requirements and policies impacted on how a person was supervised in the community, including by the police.

Men who did not have a basic level of compliance continued not to be considered for discharge. What exactly was meant by 'enough compliance' was left vague, as this concept is in part influenced by further contexts. One responsible clinician made clear that being at risk of absconding means absence of compliance, but beyond that one community nurse trusted that a good social care team can in some instances compensate for lower levels of compliance. In addition, sexual preference impacts on community resettlement planning. Risks towards children can be managed through avoidance in community settings, whilst those who pose risks towards adults need to be manageable in the presence of their victim population.

This may mean that there is a higher threshold for discharge readiness for this group. On the other hand, the fact that men in the research sample who had offended towards adults were less likely to be discharged could also indicate that only those who carry the highest risks and who have committed the most serious offences are admitted to hospital. This hypothesis is supported by the knowledge that offences by people with learning disabilities towards other people with learning disabilities are less likely to get reported than those towards children (Thompson and Brown, 1997; Byrne, 2018;) and that social care staff do at times suffer violence in the workplace with limited consequences (Brophy *et al.*, 2019; Lovell and Skellern, 2019). Further person-specific contexts include age and time spent in hospital. All these factors impact on planning for community placements.

Figure 1 illustrates that in community placements positive risk taking becomes the pillar onto which the intended treatment outcomes steady themselves. The double-sided relationship between risk management and the pro-social life is shown as a counterpoise on a seesaw: Risk management restricts the pro-social life. It takes much creativity and at times perseverance on part of the social care providers to balance risks and imposed restrictions vs. the user's goals, to achieve what they consider a fulfilling, pro-social life. As community options are often restricted a distinction was made between appearance and substance of 'freedom'. Within their social care settings, the men are made to feel

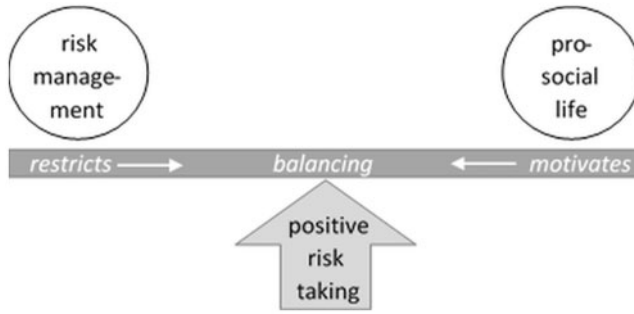

Figure 1.: Achieving successful community placements for men with remaining risks.

that they are in control. However, their routines are carefully planned, and 'independent' activities may be overseen covertly.

Risk management post-discharge may be conducted independently, in partnership with care staff (most likely) or entirely by the support team. Knowledge transfer from health to social care is essential to ensure that some of the resource–mechanism–outcome configurations of treatment for sexual offending are upheld in social care settings. For instance, the risk diary encourages self-monitoring and promotes an open dialogue between service users and staff, with service users being honest about their thoughts and actions and staff being frank and instructive in their feedback. Furthermore, the reminder cards act as motivators, but they can also be used as a communication tool between staff and user, which further promotes openness.

At the same time, the pro-social life acts as a motivator for engagement with risk management. In treatment, men had started to think about their personal goals and preferences for pro-social living. Working with these plans in the reality of community living gives the user some control in their future planning, which appeals to social work. Michael's case demonstrated that it is important to uphold both key treatment outcomes, as professionals claim that him breaching his bail conditions is not just about risk management, but that the incident also arose from him being socially isolated and having few meaningful things to do. A reality of under-occupation and limited social networks post-deinstitutionalisation was also reported by other studies (Murphy *et al.*, 2017; Bredewold *et al.*, 2020), causing a significant destabilising of risk management efforts.

Conclusion

Risk management strategies introduced by treatment transfer well into social care settings. In addition, the welfareist nature of the treatment aim to support pro-social lives appeals to social work. However, the

whole system around the user needs to work towards common goals. In the past, a risk averse culture and a lack of resources in the community were major obstacles. Incentivising discharges made a difference at the research location. Now, positive risk taking was encouraged and community resources expanded, enabling more patients with remaining risks to move to the community. Here, it was important to uphold and continue to work on both treatment outcomes, risk management and pro-social identity formation.

Post discharge social care staff continued to reinforce lessons from treatment, even using some of the treatment resources, such as risk diaries and reminder cards. For that purpose, it is imperative that social care staff are aware of a person's risks, triggers and motivators. Collaboration between health and social care was good during transitions, but additional maintenance support from forensic teams would be welcomed to ensure that knowledge remains fresh within social care teams, as well as to provide input on mundane issues to prevent these from developing into bigger problems. Finally, community resettlement planning was influenced by additional contextual factors, including local resourcing issues, the law and personal attributes, such as men's sexual preferences and levels of compliance. Some men remained in hospital with no active discharge plans in place and there is a need to think up further solutions for those affected by the most challenging contexts.

Acknowledgements

I would like to thank the men for sharing their personal histories and the carers and professionals for their time and support. Special thanks to Dr Joanne Greenhalgh, Pam Mount, Michelle Anwyl and Michaela Thomson for their invaluable ongoing support of this project, as well as Katie Place for her help with the quantitative data collection and Paula Johnson for her support during the grant writing process.

Funding

This research was funded by the Economic and Social Research Council, Grant Number: ES/L010534/1.

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