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"I kind of find that out by accident": Probation staff experiences of pharmacological treatment for sexual preoccupation and hypersexuality

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Short title: Probation staff experiences of pharmacological treatment for hypersexuality

Journal of Forensic Practice

Abstract

Purpose – This paper aimed to explore the views and experiences of probation staff working with individuals convicted of a sexual offence who have been prescribed medication to manage sexual arousal (MMSA).

Design/methodology - Semi-structured interviews were utilised with a sample of probation staff (Offender Supervisors and Managers, n=12), who supervise individuals convicted of a sexual offence, either in prison, or post-release in the community. Data were analysed using thematic analysis.

Findings - Two main themes emerged: (1) Barriers for probation staff and (2) Suspicious but hopeful. Theme one encapsulates factors that prevent probation staff from engaging with MMSA; theme two highlighted the samples' uncertainty and mistrust of the use of medication as a potential tool for risk management and scepticism about individuals' motivations, particularly in the community.

Research limitations – The main limitation of this study was the differing levels of knowledge the sample had about MMSA and their subsequent ability to discuss MMSA other than in a theoretical sense.

Practical implications - Practical implications include the need for further training for probation staff, improved collaboration between departments and ongoing support for staff to support the success of the MMSA intervention.

Originality/value – This study offers a novel perspective on MMSA - that of the probation staff supervising prisoners taking MMSA. This has not been explored before, and the findings and associated implications are of importance for the treatment and care of those convicted of sexual offences.

Journal of Forensic Practice

Introduction

Research has demonstrated that poor preparation for release from prison predicts higher rates of sexual recidivism (Dickson and Polaschek, 2015), even whilst controlling for static and dynamic predictive risk factors (Scoones *et al*., 2012). A crucial role in supporting the effective discharge of prisoners rests with probation officers, who are pivotal to the supervision/management of prisoners on release and in the community. In the UK, these are Offender Supervisors (OSs) and Offender Managers (OMs). OSs are based in custody, and support prisoners through the prison system, managing sentence planning and parole reviews. Conversely, OMs are based in the community, working with individuals to monitor risk and behaviour and ensure compliance with probation orders and licence conditions. They provide support with employment, accommodation and access to services once in the community, important factors which when not addressed, are associated with increased risk of recidivism (Hanson and Morton-Bourgon, 2005; Lussier and Gress, 2014; Willis and Grace, 2008; 2009). This is a challenging task for most ex-prisoners, but is exacerbated for those convicted of sexual offences, due to society's hostile response to these individuals (Cook and Hogue, 2013). This makes probation staffs' role pivotal in enforcing the standards of Her Majesty's Prison and Probation Service (HMPPS), and in fact, policy makers have re-instated the relationship between practitioner and service user as fundamental to changing the behaviour and social circumstances associated with recidivism (Burnett and McNeill, 2005; Craig, 2005).

A recent addition to the support available for individuals convicted of a sexual offence inside prison is pharmacological medication. This treatment, referred to as Medication to Manage Sexual Arousal (MMSA; a term adopted by the National Health Service and HMPPS in the UK), aims to reduce sexual desire, arousal and thinking for those with high levels of sexual preoccupation and/or hypersexuality. This is particularly important,

Journal of Forensic Practice

given the strong association between sexual preoccupation and increased risk of recidivism (Beech *et al.,* 2005; Hocken, 2014). The body of evidence for the use of MMSA has been methodologically limited, making conclusions restricted (see Cochrane review conducted in 2015; Khan *et al*., 2015; Adi *et al*., 2002; Baratta *et al*., 2012). Despite this, MMSA has been introduced into the UK prison system, and preliminary evaluations indicate its effectiveness in reducing hypersexual disorder (see Winder *et al*., 2014; Winder *et al*., 2017).

MMSA research to date has focused on the experiences and outcomes of individuals taking medication. However, having an understanding of the service from the staff working with these individuals is pivotal. Referrals, access to medication and general advice about MMSA are the responsibility of all staff, including probation staff. Whilst preliminary evidence has demonstrated MMSA's effectiveness, perhaps the real test will be in the community, where probation staffs' role is crucial. In addition, as healthcare records are generally speaking confidential, and therefore inaccessible to those outside this department (although for MMSA this is not the case as consent is gained to share information with relevant professionals), it is important to explore the impact this perception has on staff supporting and signposting to the intervention. This study aims to gain an in-depth understanding of probation staffs' perspectives of MMSA for individuals convicted of a sexual offence through qualitative methods.

Method

Participants

Twelve probation staff (six OSs and six OMs) participated in this research. All had extensive experience working in HMPPS and were selected through purposive sampling based on their willingness to discuss their experiences (or lack of) of MMSA.

Journal of Forensic Practice

Data Collection

HMPPS and a UK University granted ethical approval for this study and permission was obtained from the establishments. The research was advertised via email to potential participants and those interested were presented with further information at a face-to-face meeting where consent was sought.

Data were collected through semi-structured interviews. The interview schedule was developed following consultation with MMSA staff and shadowing of probation staff to better understand their daily tasks with (ex)prisoners. The interview schedule explored the following areas: (i) views, knowledge and experiences of MMSA; (ii) impact on risk; (iii) compliance and; (iv) post-release considerations. Interviews were recorded on a password protected dictaphone and conducted in a private room within the prison/probation establishment. Participants were informed of rights to withdraw and that their identity would be protected by replacing real names with pseudonyms.

Analysis

The data were analysed using thematic analysis, based on guidance from Braun and Clarke (2006). This approach was adopted for its ability to work with larger qualitative samples in a flexible way in order to identify patterns across data and organise and interpret these into themes (Braun and Clarke, 2006). This method of analysis involved the authors transcribing, reading and rereading transcripts to increase familiarity. Initial impressions of the data were then noted and codes were used to group notes into preliminary themes. These themes were reviewed and modified and co-authors 'audited' the analysis by cross-checking against original transcripts to assess the validity and reliability of the interpretations and final thematic structure (Lincoln and Guba, 1985).

Journal of Forensic Practice

Findings

The interviews offered a rich set of data of staff experiences, with the main discussions comprising the barriers staff experienced in relation to MMSA, as well as their contrasting suspicions but hope for the medication's effectiveness. These and the associated sub-themes are discussed below, with a summary of themes in table 1.

[INSERT TABLE 1]

Superordinate theme 1: Barriers for Probation Staff

Participants discussed barriers that hindered their engagement with MMSA, including feeling excluded from the treatment process, having limited knowledge of the medication and a perceived lack of support when trying to seek information.

Sub-theme 1:1 Knowing who is taking MMSA – 'I kind of find that out by accident'

Participants proclaimed they were left out of the MMSA process; they were not informed when referrals take place for (ex)prisoners in their care, or about progress on medication:

> the problem is unless the prisoners discloses to us that they are taking it we wouldn't know that they are taking it so (Smith; OS)

> I think there's quite a few people who have sex offenders on their caseload who are on it but you wouldn't necessarily know (Derek; OM)

> I'm not told that they've been referred, I kind of find that out by accident and, erm, and when they've been on it a while I don't get any feedback unless I'm proactive and go and ask for it…and that's frustrating because you can't be proactive if you don't know they're on it (Florence; OS)

Journal of Forensic Practice

These extracts reflect a consistent theme of a lack of knowledge about who is taking MMSA. Participants described often finding out 'by accident', usually from the service user themselves. Florence explains how this inhibits them from being proactive in their role of supporting (ex)prisoners.

> the whole purpose of anti-libidinal[1] medication is about risk, it's demonstrating that they're doing something that's hopefully gonna assist in managing their risk so I don't think there should be any confidentiality surrounding anti-libidinal medication (Jack; OS)

> but when it comes to risk I do, I think we should be told because if it is a risk reducing medication, or if we can be involved in reporting how effective it is, we can work with them in supervision (Smith; OS)

> If someone's been prescribed anti-libidinals in the first place that means in all likelihood they are totally sexually preoccupied or had offence related fantasies that have interfered with their normal functioning so therefore I think I'd need to know as that's offence related (Karen; OM)

These extracts highlight one of the key discussion points of participants: the implication taking MMSA has on an individual's perceived risk. Karen demonstrates her belief that those on medication are likely to be consumed by their sexual fantasies and at an increased risk of offending – key information for probation staff managing offence related risk. Alternatively, Smith and Jack viewed the medication in a more positive light, as having the potential to reduce risk. However, all participants agreed that probation staff should be informed of anything that may affect (ex)prisoners' risk.

[1] Anti-libidinals is a term frequently used by participants to refer to MMSA. It was previously used to describe the medication before the term MMSA was adopted nationally.

Journal of Forensic Practice

Participants described the impact of not being informed; Derek (OM) stated that 'It would be no good doing fantasy work with someone on medication when that's its target', highlighting that the 'not knowing' could affect his competency in working towards and developing an appropriate risk management plan:

> We need to know that information because we are asked that information at parole hearing invariably (Winnie; OS)
>
> It's quite embarrassing at times because maybe I don't know, maybe the Offender Managers got hold of it, or maybe psychology know about it for some reason and they do their SPRE[2] and they'll write all about that and I've already done my SPRL[3] and I'm thinking 'what do you mean anti-libidinals, when did this happen? (Florence; OS)

These extracts represent a majority voice for participants, that not being informed who is taking medication impacts their ability to supervise effectively: 'if we're not informed about all that, then perhaps we're not doing them a good service' (Winnie; OS).

Participants frequently discussed the feeling of being 'left out of the loop' (Winnie; OS) and Smith commented that 'it's very silent working', portraying an isolated experience of MMSA. These extracts demonstrate the detrimental practical implications of not being informed when individuals are taking MMSA and how this affects participants' perceived competency in their role. Winnie (OS) comments that she 'would like to see us far more involved' in the process, a sentiment that is echoed throughout the interview transcripts.

Sub-theme 1:2 – 'Us and them'

Closely related to the findings already discussed, this sub-theme highlights the disparity felt between departments, and how this exacerbates the barriers already mentioned. Participants felt there were distinct separations between themselves and psychology/psychiatry:

[2] Sentence Planning Report
[3] Offender Supervisor Report

Journal of Forensic Practice

'Psychology can be a bit shady with us' (Jones; OS); 'I feel that you've got psychology and psychiatry and we're almost an add on' (Winnie; OS). These comments portrays a sense of hostility between the Offender Management Unit and psychology/psychiatry and the use of the word 'shady' implies a feeling of distrust and suspicion. Participants explained how the disparity between departments extends to the MMSA process:

> it's been quite 'us and them', it's like we've got some information which we do have to share like the SARN reports and like that but regards to that [MMSA] it doesn't seem to be a main aspect of a prisoners life, because it's only voluntary it's not something that's generally discussed (Jones; OS)

> I think it's very rare that an offender supervisor would make that referral, and I think part of that is, is the feeling of being left out of those discussions really, not being part of it and almost perhaps a feeling of well that's not our domain is it, when clearly it should be and it can be, erm, but, I- I can't speak for everybody, but certainly I feel quite excluded from that process (Winnie; OS)

Staff talked about feeling excluded from the MMSA process, and it not being their 'domain'. Instead they viewed psychology/psychiatry as the departments in charge of the medication. Even those who were less clear on the MMSA process held this view: 'its all medical in confidence, I think, is it via the healthcare, is it via programmes, I don't know' (Ross; OS). This demonstrates an assumption by probation staff that MMSA is not their responsibility. In the extract above, Jones makes an interesting point that, given MMSA are not mandatory, they are not discussed or included in reports in the same way that mandatory parts of a prisoner's sentence plan are. Karen (OM) shared her feelings that there is a 'preciousness in regards to the medication', which she does not understand when their role as probation staff is to manage, make assessments and liaise with agencies in order to manage risk, as highlighted in Winnie's dialogue:

Journal of Forensic Practice

> it's (anti-libidinals) kind of kept in the realms of psychiatry and psychology, perhaps they think that if we get hold of it we'll suddenly be referring everybody, saying give him these drugs (Winnie; OS)

Similar to Karen's feelings, Winnie makes a cynical comment that perhaps probation staff are not trusted by psychiatry or psychology to make appropriate referrals, and that psychology view MMSA as something specialist to their area, making them hesitant to share it with other departments. This appears to lead to feelings of exclusion, causing a removal of responsibility in relation to referrals, perceived as 'not our domain'.

Sub-theme 1:3 – MMSA knowledge - 'I'm very naive about it'

Similarly, a prevailing concept was participants' lack of awareness about MMSA: 'I don't really know much about it' (Smith; OS); 'I'm very naive about the two [types of medications]' (Winnie; OS); 'I'm very limited to what I know about it' (Ross; OS). These comments are representative of the sample:

> I think it's the lack of information about the medication and erm, just feeling completely out of the loop in terms of it (Sarah; OM)

> I feel a bit out the loop about how the medication feeds into our line of work and what it actually does, I don't feel as though I know anything much about it at all. (Steve; OM)

> They don't tell us, nobody tells us, I- I don't even know who to contact (Florence; OS).

These statements and in particular Florence's statement that 'nobody' tells them, strongly emphasise this feeling of being left out. This led to feelings of uncertainty surrounding where to seek guidance – a ubiquitous sentiment in this sample. Winnie (OS) asserted she felt 'quite

Journal of Forensic Practice

ignorant' about MMSA. Similarly, Jones felt a lack of confidence to talk about MMSA in a professional capacity:

> I'm not comfortable within that area, it's not my speciality to feel like I could say that with a parole board, so I'd rather not mention it…it just seems like one big flaw… we can't ask about the unknown…I know so little on it that I couldn't really ask him much about it (Jones; OS)

Jones admits to an active avoidance to talk about MMSA, due to a lack of confidence. The impact here is that staff's lack of knowledge may affect prisoners' experience in prison, and could lead to avoidance of an important aspect of an individual's rehabilitation journey. Jones went on to say that if more was known about MMSA within the department, they could be more proactive in promoting it. This was supported by Florence (OS), who stated 'I think they'd fit in very well if I knew about them'.

This suggests practical training is required to inform staff of their role regarding MMSA. If the delivery of training for MMSA is successful, probation staff should be aware of its purpose, how to manage it and 'get advice on what people might be experiencing when they are using it' (Derek; OM), leaving them in an better position when it comes to supporting and managing individuals on MMSA.

These three sub-themes highlight a perception from participants that they are not included in the MMSA process. They feel excluded by psychology and psychiatry, and this appeared to decrease moral, and cause further distance between departments and the MMSA intervention. Despite this, participants continually talked of the importance of being involved in the MMSA process, and of being informed when a (ex)prisoner is taking medication, as the potential implications on risk and an individual's overall journey through the criminal

Journal of Forensic Practice

justice system are critically important to them. Participants gave examples of how this knowledge would improve their abilities in their role of risk management.

Theme 2: Suspicious but hopeful

Throughout the course of interviews, participants oscillated between concerns they had about MMSA, which prevented them from fully subscribing to the treatment, and their belief that the medication has the potential to be an important piece of the puzzle in terms of risk management. These conflicting feelings are the basis for the following sub-themes.

Sub-theme 2:1 – MMSA as a 'manipulation tool'

Several of the participants appeared suspicious of (ex)prisoners' reasons for consenting to take MMSA:

> If they can use it as a manipulation tool to get a positive recommendation, but then not take medication or withdraw from it as soon as they've got what they wanted, there's always a danger, or they could be making a decision based on getting released but they're not really that committed (Smith; OS)

> They might just be doing it for 'brownie points' to prove to outside probation, whatever, that you know 'I'm capable of doing this and I want to do this' and truthfully it's not, it's because they want to reduce their time in custody (Jones; OS)

> Someone could come in and be manipulative and say they are taking it when they are not (Derek; OM)

These extracts indicate the concerns and distrust some staff held about individuals convicted of a sexual offence - in particular a suspicion towards their motivations to comply. The primary concern appears to be that individuals can use MMSA as a 'manipulation tool' to persuade staff they have reduced their risk when this may not be the case. These opinions suggest that parole boards and probation staff would look favourably on MMSA, and be more

Journal of Forensic Practice

likely to recommend release for an individual taking MMSA. This was in direct contrast to how some participants felt about those taking MMSA, where they felt suspicious of the credibility of (ex)prisoners' self-reports:

> so the ones who are telling me yeah, yeah its working great I'm able to now concentrate, and that - you know I do want to believe them, I do, but in the back of my mind I've got, unfortunately I've got that doubt, from perhaps learnt behaviour on my part from people who've let us down (Jack; OS)
>
> Sex offenders can be very skilled at presenting themselves in a certain way (April; OM)

Jack describes his difficulty trusting the self-reports of those taking medication. He recognises that his 'doubt' is influenced by previous experiences of being let down. Similarly, Karen (OM) states that there is an 'element of mistrust, in a sense that from the start, I'm not going to believe anything you [offenders] tell me'. This was a common issue for participants who did not feel comfortable relying on self-reports. However, Winnie (OS) stated that in closed conditions, like prison, the majority of work completed with prisoners is measured by self-report and thus does not 'see that as any more of a problem than any other kind of strategy'.

Although there was a general scepticism among all participants, OMs were particularly sceptical about the effectiveness of MMSA in terms of reducing risk:

> I would obviously put it in a risk management plan that he's on anti-libidinal medication but I don't feel confident that it will actually stop them. It's a bit like what they say about eunuchs, they still try to have sexual behaviour even though they were incapable of it (Sarah; OM)

Journal of Forensic Practice

Sarah held a sceptical view about MMSA, explaining that even if the medication makes sexual activity impossible, individuals will still try to engage in it. Similarly, April (OM) stated: 'Our view was that it doesn't stop the way you think but then maybe probation officers are biased'.

In contrast, for some OS probation staff, taking the medication was perceived as a genuine attempt to reduce and manage risk:

> When the prisoner says they wanna take it then I suppose it makes it, a, a more valid decision, so they're not trying to manipulate or look good (Smith; OS)

> I think if somebody is self-aware enough to be saying to staff 'I'm having intrusive thoughts, I'm becoming sexually preoccupied' I think yes, we have to be satisfied with their self-report (Florence; OS)

> Mr X, who's been sexual preoccupied all his adult, all his life actually and who is very genuine in wanting to manage his risk and not come back here, for me it's, it's kind of another piece to that jigsaw, it's an added thing to say to a parole panel, look he, he's very genuine in his, his desire to not reoffending (Winnie; OS)

These extracts indicate that the voluntary nature of MMSA helps staff, and particularly Oss, to view motivation as more 'valid' and trustworthy, an opinion echoed in Florence's quote. Winnie's extract portrays a sense that some individuals appear more sincere and transparent in their motivations than others, leading her to feel more open to recommending the individual for release at a parole board. This indicates the subjective nature of the work and the difficult balance when relying on self-report. Winnie's extract highlights how MMSA is viewed as a part of a puzzle, a view echoed by other participants:

Journal of Forensic Practice

> Think back to the argument that it's only part of their tool box then you would hope their attitudinal changes and their cognitive changes were such that would help them manage their risk anyway (Karen; OM)

This more positive outlook seemed to feed into a general feeling of hope that MMSA can be a successful tool in reducing risk: 'I think if they could structure it more, then it could be quite a strong key' (Smith OS); 'I think it could be part and parcel of a risk management plan' (Winnie; OS).

This sub-theme demonstrates that for some probation staff, there is considerable suspicion around the motives for taking MMSA; opinions regarding the sincerity of motivation are largely subjective. The discomfort of relying on self-report was a common issue, despite the fact that the majority of work undertaken to reduce risk is evaluated through self-report. This heightened sense of cautiousness is construed based on their previous experiences of the interpersonal characteristics of individuals convicted of a sexual offence. However, the voluntary nature of the medication, as well as individuals' openness regarding their need for MMSA seem to alleviate some of these concerns and enable some more positive opinions - that MMSA has value as an adjunct to other treatment.

Sub-theme 2:2 – Worries for the future

This final sub-theme portrays participants' concerns about the viability of MMSA in the community. In particular, concerns were expressed about how such a treatment could be managed and prescribed in the community, and the issue of compliance:

> if he chooses not to continue it in the community, it's not really reducing his risk in anyway, and it's not really something that can be measured by an Offender Manager in the community to me because it's relying on them telling you the truth (Jones; OS)

Journal of Forensic Practice

This extract summarises the views of most participants - that once in the community, such a treatment cannot be managed as effectively. It reiterates the issues presented in the previous sub-theme, regarding reliance on self-report. Participants recognised that whilst in custody, compliance with medication, although not without its difficulties, is something that can be implemented much more easily. However once in the community, there was a consensus that individuals would be less compliant:

> whilst they're in here they have to, show that they're willing and they're wanting to change…but when they get back into the stimulus of society, and they're getting comfortable again, they stop practicing those skills…because perhaps they don't feel they need to anymore and they lapse (Jack; OS)

> I wouldn't be at all surprised if I was a community based probation officer if somebody was reporting those things to me, saying I don't want to be on these [MMSA] anymore. I think we're in quite a sterile environment here and they - they see the advantage to them of taking this medication at this particular stage (Winnie; OS)

Jack expressed his view that without the demands of the prison environment, the motivation for continuing treatment is lost. This sentiment was echoed by Jones (OS): that the individuals will be 'counting down the days till they're off it [their licence]', so they can stop the medication. Similarly, Winnie's extract suggests that the motives for taking MMSA in prison will be gone once in the community. This was a prevalent theme for all participants, portraying their suspicions about the true reasons for taking MMSA.

Participants were concerned about the logistics of being prescribed MMSA in the community:

Journal of Forensic Practice

> When he was released he couldn't get prescribed it…so he went on to...be recalled linked to increased sexual thoughts so coming off it seems to be the danger (Smith; OS)
>
> The concern was initially when he was released, because he'd only be released with a week's worth of medication, would the GP prescribe it… we said 'just tell 'em it's an anti-depressant'- just tell 'em 'it's an anti-depressant' until you get to see a reviewing psychiatrist, because I think if the pathways for being released into the community and continuing with the medication were stronger then, it's not gonna stop somebody from reoffending but I do think it's a major crutch (Florence; OS)

These extracts convey concerns about the structures in place to support ex-prisoners in accessing MMSA in the community. Both participants spoke of problems associated with access to MMSA, raising concerns about GPs' awareness of MMSA (or perhaps attitudes towards this type of medication), particularly for SSRIs which are licenced to treat depression, not sexual preoccupation.

This was a sentiment shared among participants: 'I would send them to the GP but I wouldn't really know if that's something they can prescribe' (Derek; OM). Participants lacked insight into the process and how medication can be obtained in the community, and this seemed to be exacerbated by lack of communication: 'GPs don't routinely give us any information and they're very difficult to get hold of' (April; OM); 'We don't have any communication with the prescribers…It would be interesting to have that communication for risk management purposes' (Sarah; OM).

These issues reflect a general concern that pathways are not in place to support prisoners on release. It would seem that some participants believe it could be professionals that fail the (ex)prisoners and create obstacles to engagement. Perhaps GPs lack the

Journal of Forensic Practice

knowledge to confidently prescribe MMSA, creating barriers for individuals trying to engage in this treatment. Given that SSRIs are not currently licenced for the treatment of hypersexuality within the UK NICE guidelines, guidance for GPs is limited. Moreover, the uncertainty surrounding access to MMSA in the community among the probation staff of this study highlights the need for more support in order to promote the throughcare of medication.

Discussion

This explorative study demonstrates the barriers that are faced by staff engaging with a new treatment initiative like MMSA. A key difficulty highlighted was a lack of awareness and knowledge of the medication among participants. This caused apprehension and a lack of confidence when dealing with individuals taking MMSA, with some participants admitting to overlooking the medication altogether within their role. This is a key finding, considering the pivotal role probation play in (ex)prisoners' rehabilitation journeys (Burnett and McNeill, 2005), and highlights a gap in staff awareness, which not only causes apprehension, but increases the likelihood that those taking MMSA are receiving a disservice. This is consistent with the findings of Lievesley, *et al*. (2014), who interviewed service users taking MMSA and treatment staff and revealed a need for further education of psychology staff and concerns about a lack of knowledge within other departments.

When MMSA was introduced into the prison establishment within this study, training was offered to OSs. However, few from this sample participated, and as far as the authors are aware, training has not been offered to any Offender Managers in the community. This suggests that staff would benefit from MMSA training becoming a mandatory part of staff development in prison and the community, particularly as both this research and findings from Lievesley *et al*. (2014) demonstrate staff are not always aware that making referrals for

Journal of Forensic Practice

MMSA is a requirement of all staff. If adequate training is implemented, this could inform good practice and provide further opportunities, not just for (ex)prisoners taking MMSA, but for those who are contemplating the treatment and need advice and support from their assigned probation officer. It may also increase participants' belief in the efficacy of treatment (Hogue, 1995), something which was lacking for the majority of within this study.

Participants held a sceptical view of MMSA, largely based on their apprehensions regarding its effectiveness, and concerns about individuals using MMSA as a manipulation tool to appear less risky. This seemed to link with participants' scepticism about self-reports, a recognised concept amongst personnel working with individuals convicted of a sexual offence (Weekes *et al*., 1995), which can hamper professional practice (Lea *et al*., 1999). However, the self-report nature of measuring success is true of any current offender intervention. As well as concerns that (ex)prisoners may take MMSA to appear less risky, there were concerns about what taking MMSA may actually reveal about an individual's risk – perhaps making them appear uncontrollably risky. A similar concern was found among prisoners taking (or referred for) medication in the interviews conducted by Lievesley *et al*. (2014). Prisoners reported concerns that the parole board would view them as more risky if they took MMSA, and one participant reported that a prisoner had been told by probation that taking medication 'would go against him at a parole board meeting' (p. 18). This confirms that prisoner concerns about appearing more risky are not unjustified, and may impact upon referrals, as many prisoners may refuse medication for this reason. It is therefore important to establish the actual views and decisions of parole boards in relation to MMSA. Despite controversial concern that individuals may take MMSA to try and appear less risky, and whilst some parole boards do view MMSA as a positive risk management tool, others view taking medication as a sign that an individual is at such increased risk that they need external controls such as medication to help them cope, and may be less willing to

Journal of Forensic Practice

recommend progression as result (K, Hocken, personal communication, 24 August 2015). Further research is recommended, to explore the impact MMSA has in parole boards and the attitudes and experiences of those appearing on parole boards with an individual taking MMSA.

The issues surrounding MMSA are not limited to decisions about release, but extend to the transition from prison to community, where access to medication is reported here as limited. This supports the findings of Lievesley *et al*. (2014), with participants expressing not just concern, but real life examples of individuals who have been unable to access MMSA in the community. In this study, OMs in the community were generally aware that referrals for MMSA occur in custody, but like OSs, they had limited insight into the support structures that are available to ensure continuity of care. Participants felt that the lack of communication between agencies accentuated their uncertainties, causing challenges for their role in the management and supervision of (ex-)prisoners. This is not surprising, as there is currently no clear protocol for the throughcare of MMSA from prison to the community, and there is no research on the efficacy and viability of MMSA in the community, a recommendation for future research. Very few OMs in this study noted individuals on their caseload taking MMSA, yet as treatment awareness increases, it is likely more people will be taking the medication upon release. As such, for those progressing into the community, a precise and effective support structure is incredibly important to ensure they receive continuity of care. Particularly because factors associated with elevated risk are intensified when in the community (Lussier *et al*., 2011), and there is a clear association between poor release planning and increased risk of sexual recidivism (Dickson and Polaschek, 2015; Scoones *et al*., 2012). Clear guidelines on where to seek advice and support for staff will enable a smoother and more risk adverse transition from prison to the community. This is particularly important considering the national precedence for MMSA recently set by NOMS, meaning

Journal of Forensic Practice

that MMSA is now offered across a number of UK prisons. Training is therefore vital to ensure those who are in need and who have a desire to take MMSA are offered this service, and receive the necessary throughcare when released into the community.

Related to the above, and likely a precipitating factor to the poor throughcare, was the apparent lack of unity between departments discussed in this study. This was mostly an issue expressed by OSs, who appeared to attribute responsibility and knowledge of MMSA to the psychology department. Participants expressed exasperation about not being notified by an official source when someone starts taking MMSA, and seemed to attribute this responsibility to psychology/psychiatry. Within this, there was concern about medical confidentiality and whether they could have access to such information - another issue for staff training, as probation staff seem unaware that consent is gained from anyone taking MMSA for their records to be shared with relevant professionals. This issue of a lack of communication between probation staff and psychology/healthcare results in a key staff group not being involved in a significant part of a (ex)prisoner's treatment journey. For the participants of this study, this led to a sense of feeling left out, less important and less capable, ultimately leading to a removed responsibility from the process. This is significant, considering the pivotal role that these staff play in individuals' journeys through the criminal justice system. The matter seems to tap into an unspoken hierarchical issue between departments, an issue which is likely causing de-motivation and removal of responsibility, preventing probation staff from making referrals for those who would benefit. Research demonstrates that communication of feedback and providing clear information on job instructions, rules and policies by those superior, predicts job satisfaction (Frone and Major, 1998; Miles *et al*., 1996), and is another recommendation of this study, as this in turn is likely to improve job performance. Moreover, training with a mixture of staff in different roles is recommended, with the aim of overcoming the apparent barriers caused by disparity between departments. This will create

Journal of Forensic Practice

clearer communication pathways between departments, increasing unity and bridging the perceived gap between who is responsible for MMSA.

Limitations

A limitation of this research is that participants were interviewed in their place of work, and although interviews were conducted in a private room, they may have been subject to social desirability bias (Grimm, 2010). However, upon reviewing the interviews and the nature of participants' discussions, the authors feel that participants were willing to be open, for example discussing unreservedly their lack of knowledge in certain areas. This however leads to another limitation, as the sample had varying levels of knowledge about MMSA, with some not able to answer all interview questions. Despite this, rich data was collected, and inability to answer certain questions simply served to support the gaps in knowledge that was a consistent theme throughout the data. Finally, qualitative research has limitations in terms of generalisability, due to small sample sizes, and as this research only sampled from one prison and probation establishment within the East Midlands, elements of the findings may only be representative of this geographical location. Nevertheless, the UK's first trial of MMSA inside a prison was piloted in this area, and thus the experiences and perspectives of these staff were deemed relevant and important.

Conclusions

This qualitative study adds to the limited literature exploring the effectiveness of MMSA with sexually preoccupied individuals by exploring both OS and OMs' personal experiences. The research has highlighted several issues which may prevent staff from fully engaging and incorporating MMSA into their job roles. Despite this, there was a sense of hope among participants regarding the utility of MMSA, as well as a desire to be more involved and feel a part of the process. Moreover, from the findings, it is possible to see how this can be

Journal of Forensic Practice

improved upon, demonstrating the value of this research. The research highlighted concerns about the implementation of MMSA, disparate communication between departments and a mistrust of the self-reported effects of the medication. A key finding was the concern about accessing MMSA in the community. This is not a straightforward process and little is known among the sample about how individuals can access the medication post-release. Given that the percentage of individuals convicted of a sexual offence released on licence is increasing (Home Office, 2013), efforts to maximise the effectiveness of professional input should be a high priority. Greater training for both samples and other independent bodies may help bridge the gap between prison and community and encourage all agencies to support an individual's reintegration into society. Ultimately, adopting a multidisciplinary approach to MMSA will help facilitate its utility and contribute to its successful delivery.

Implications for practice

- Research is required to identify how MMSA is viewed in the community by professionals involved in ex-prisoners' community care (including GPs).
- Further research into the views of those involved in parole boards is suggested.
- Research to explore efficacy and viability of MMSA in the community is needed, with no research currently available. This may confirm/deny some of the current concerns about individuals continuing medication on release.
- Similar research should be conducted in other establishments to determine if the views expressed here are coherent with other samples.
- Staff training on MMSA (including information on staff responsibilities, making referrals, the effects [and side-effects] of MMSA, and access to treatment

Journal of Forensic Practice

information/progress) appears necessary for the successful implementation of MMSA across prisons and in the community.

- Staff training should encourage liaison between departments, not just through training materials, but by adopting an inclusive approach, inviting members of staff from different departments to attend together (particularly healthcare, psychology and probation).
- As well as training, staff may need additional guidance when reporting on MMSA in parole boards. This could take the form of an allocated MMSA mentor for example.
- A precise and effective support structure for the release of individuals taking MMSA is required to ensure continuity of care.

Journal of Forensic Practice

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Journal of Forensic Practice

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Journal of Forensic Practice

Table 1. Superordinate themes and sub-themes

Superordinate themes	Sub-themes
1 Barriers for probation staff	1.1 Knowing who is taking MMSA – 'I kind of find that out by accident' 1.2 'Us and them' 1.3 MMSA knowledge – 'I'm very naive about it'
2 Suspicious but hopeful	2.1 MMSA as a 'manipulation tool' 2.2 Worries for the future

Journal of Forensic Practice