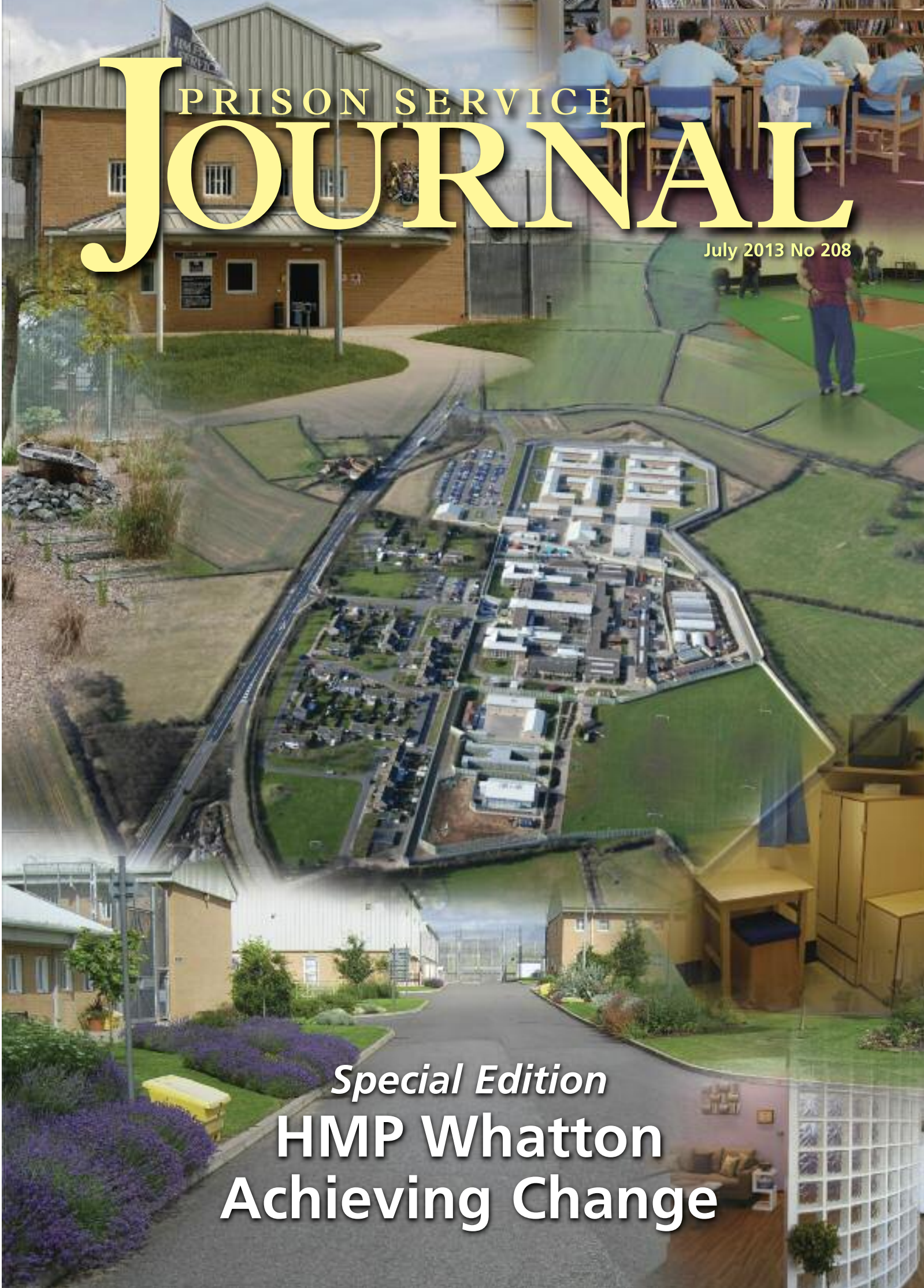

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HMP Whatton Achieving Change

The Use of Medication to Treat Sexual Preoccupation and Hypersexuality in Sexual Offenders

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Context

Research is continually seeking to improve our understanding of factors that increase individuals' risk of reoffending. Findings have identified that sexual preoccupation and/or deviant sexual interests significantly predict sexual, violent and general recidivism[1,2]. Sexual preoccupation is defined as 'an abnormally intense interest in sex that dominates psychological functioning'[3], potentially resulting in individuals engaging in a high frequency of behaviours to relieve sexual urges. A high frequency of sexual behaviours or an excessive sexual appetite is often referred to using a number of terms, including hypersexuality[4].

In the UK interventions with sexual offenders primarily use psychological treatment methods to address different aspects of offending and teach skills to prevent reoffending. Sex Offender Treatment Programmes (SOTP) are the standard treatment methods in UK prisons[5]. However, these programmes cannot always cover the range of deviant sexual fantasies and arousal present in some sexual offenders,[6] or psychological treatment alone might be insufficient[7]. This may result in treatment needs relating to deviant sexual fantasies, sexual preoccupation or hypersexuality being left unmet. Furthermore, if sexual urges or thoughts are particularly intense, this can hinder an individual's ability to focus in treatment programmes and apply management techniques[8].

These limitations with psychological treatment programmes, and the significant public concern about sexual offenders,[9] has encouraged the use of pharmacological treatments employing medication to reduce deviant sexual arousal, fantasies and behaviours, when psychological treatment alone is not enough[10].

Treating sexual offenders with medication to reduce sex drive has been used since the 1940s[11]. In some countries, the use of pharmacological treatment is mandatory, or a condition of release from prison. In California, for example, it is a condition of parole release for repeat sexual offenders with victims under 12 years of age[12]. However, there are ethical implications, particularly when considering side-effects

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10. Bourget, D., & Bradford, J.M.W. (2008). Evidential basis for the assessment and treatment of sex offenders. *Brief Treatment and Crisis Intervention*, 8(1), 130-146.
11. Harrison, K. (2008). Legal and ethical issues when using antiandrogenic pharmacotherapy with sex offenders. *Sexual Offender Treatment,* 3(2). Retrieved from http://www.sexual-offender-treatment.org/2-2008_01.html
12. Ibid.

of some medication, and 'there are still problems with maintaining compliance, especially when the treatment is in a pill form and administered by the offender'[13]. While compliance issues may still exist with voluntary treatment, the initial motivation to comply is different, that is to reduce sexual preoccupation and behaviours[14] rather than to secure release. For these reasons, some countries use pharmacological treatment on a voluntary basis.

Since 2007 protocols have been established within the United Kingdom to allow the pharmacological treatment of sexual offenders on a voluntary basis. This is done through referral from prison or probation and thus is currently only available for convicted sexual offenders within the Criminal Justice System[15]. Critics have argued that using medical intervention with sexual offenders diminishes acceptance of responsibility[16]. However, pharmacological treatment is viewed as a supplement to psychological treatment rather than an alternative and 'needs to happen in combination with psychological treatment to help people understand their sexual thoughts and to challenge deviant thought processes'[17]. In 2007, a three-year pilot study was introduced into the prison and probation services[18] whereby individuals could undergo assessment, and if appropriate, access medical treatment. Following this pilot, the Department of Health, HMPS and Nottinghamshire Healthcare NHS Trust have continued to fund ongoing pharmacological treatment of individuals at HMP Whatton.

Critics have argued that using medical intervention with sexual offenders diminishes acceptance of responsibility.

The service at HMP Whatton

Pharmacological medication has been prescribed at HMP Whatton since 2009 with 64 offenders referred for the service to date. Individuals are considered appropriate for referral in cases where mental health issues are identified that contribute to offending or act as a barrier to treatment, or through evidence of one of the following:

- ❒ Hyper-arousal (e.g. sexual rumination, sexual preoccupation, difficulties controlling sexual arousal, high levels of sexual behaviour)
- ❒ Intrusive sexual fantasies or urges
- ❒ Sexual urges that are difficult to control
- ❒ Sexual sadism or other dangerous paraphilias, or repetitive paraphilic offending such as voyeurism or exhibitionism.[19, 20]

Unlike the pilot, which placed emphasis on treatment managers to make referrals, HMP Whatton's scheme is dedicated to educating all staff in this process, ensuring everyone has the understanding and confidence to make a referral where appropriate. Although referrals can be made at any point in an offender's sentence, if the need for medication can be established early it will help to identify and address this as a risk factor earlier. For this to be achieved, the input of staff outside of psychology or programmes is required because offenders may not come into contact with psychology for some time. It will also help prevent any negative impact on later psychological treatment programmes. Behaviours associated with sexual preoccupation or hypersexuality are more likely to be picked up by those in frequent contact with offenders (e.g. wing staff) and it is therefore vital for all staff to have an understanding of this.

Individuals are referred by any member of staff completing a referral form. As the service is voluntary, the referral process requires that individuals have a clear understanding of what they are being referred for and why. As such, information sheets have been developed to ensure understanding, including adapted versions for individuals with intellectual or learning disabilities (ID/LD), and consent is required for each referral. Following referral, all individuals are assessed for suitability by the psychiatrist and if appropriate, this assessment will also determine which medication is most suitable for each individual.

There are two main types of medication used at HMP Whatton: the Selective Serotonin Re-uptake

13. Ibid.
14. Parhar, K.K., Wormith, J.S., Derkzen, D.M., & Beauregard, A.M. (2008). Offender coercion in treatment: A Meta-Analysis of Effectiveness. *Criminal Justice and Behaviour*, 35(9), 1109-1135.
15. See n.11.
16. Meyer, W.J., & Cole, C.M. (1997). Physical and chemical castration of sex offenders: A review. *Journal of Offender Rehabilitation*, 25(3-4), 1-18.
17. Home Office (2007). Review of the protection of children from sex offenders. London: Home Office, p. 14.
18. NOMS (2007). Medical Treatment for Sex Offenders, Probation Circular 35/2000, London: NOMS.
19. HM Prison Service (2008). Psychiatric Assessment for Sexual Offenders. Interventions Group. HM Prison Service.
20. See n.18

Inhibitor (SSRI), such as Fluoxetine, and Anti-androgens, such as Cyproterone Acetate (CPA). SSRIs, more commonly known for their treatment of depression, anxiety and obsessive compulsive disorder (OCD), act by increasing the levels of Serotonin in the brain, which is known to interact with Testosterone in the regulation of sexual behaviour. SSRIs are documented to reduce deviant sexual behaviours in patients with various paraphilias,[21] the intensity of sexual fantasies and obsessions[22] as well as sex drive and deviant sexual behaviour in sexual offenders.[23] This reduction in sex drive is not a predictable effect of SSRIs, instead the aim is to reduce the intensity of the sexual fantasies and urges, allowing individuals to acquire and utilise knowledge and skills developed through psychological treatment[24].

Anti-androgens act by reducing Testosterone levels and moderating sex drive[25] and as such has a well-researched evidence base for treating sexual deviancy[26]

Individuals usually begin on a low daily dose of SSRIs. If no satisfactory results are reported, they can move on to a higher dosage and if, after four-six weeks, there are still no improvements, a low dose of anti-androgen can be added and increased as appropriate[27]. This process is thus tailored to the individual's needs and responsivity to medication. Regular contact is maintained with the psychiatrist to monitor progress, providing the opportunity for individuals to discuss the medication and raise any concerns. Following release into the community, the psychiatrist will make arrangements to allow the individual to continue medication.

Many have criticised this treatment on the basis that it prevents future healthy sexual activity and effectively chemically castrates individuals indefinitely[28]. However, the effects can be reversed and although offenders are encouraged to continue medication on release the aim of this treatment is to reduce deviant thoughts and arousal without ruling out the possibility of future healthy sexual relationships. SSRIs in particular aim only to reduce deviant sexual interest whilst maintaining healthy sexual arousal[29]. While anti-androgens do reduce all sexual arousal, the aim is to decrease dosage over time to allow an individual to promote healthy sexual interests. With the application of skills learned through psychological treatment, which all offenders on medication should receive[30], this should be possible for most individuals.

Many have criticised this treatment on the basis that it prevents future healthy sexual activity and effectively chemically castrates individuals indefinitely.

The evaluation

In order to understand if or how the medication reduces sexual preoccupation, improves responsivity to psychological treatments and reduces consequent sexual reoffending, the impact of the medication is being evaluated. A comprehensive programme of qualitative and quantitative research is being conducted by the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) in the Division of Psychology at Nottingham Trent University. Qualitative research is a method of enquiry which allows for detailed and personal exploration of experiences. Within the research programme this method has been used to explore the experiences and thoughts of offenders on medication and staff working closely with those taking medication.

Quantitative research allows for investigation via statistical, mathematical or computational techniques. It is numerical in nature and is used to produce

21. Kafka, M.P., & Hennen, J. (2000). Psychostimulant augmentation during treatment with selective serotonin reuptake inhibitors in men with paraphilias and paraphilia-related disorders: A case series. *Journal of Clinical Psychiatry*, 61, 664–670.
22. See n.6.
23. Garcia, F.D., & Thibaut, F. (2011). Current concepts in the pharmacotherapy of Paraphilias. *Drugs*, 71(6), 771-790.
24. See n.19.
25. Thibaut, F., De La Barra, F., Gordon, H., Cosyns, P., Bradford, J.M.W., & the WFSBP Task Force on Sexual Disorders. (2010). The world federation of societies of biological psychiatry (WFSBP): Guidelines for the biological treatment of paraphilias. *The World Journal of Biological Psychiatry*, 11, 604-655.
26. See n.23.
27 See n.25.
28 See n.11.
29. Bradford, J.M.W. (2001). The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behaviour. *Canadian Journal of Psychiatry*, 46, 26-34.
30. Hill, A., Briken, P., Kraus, C., Strohm, K., & Berner, W. (2003). Differential pharmacological treatment of paraphilia's and sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, 47(4), 407-421.

unbiased results which may be generalised to a wider population. This method has been used to investigate the effects of the medication. While the evaluation is ongoing, some of the preliminary findings to date are discussed below.

Part 1: Analysis of clinical and psychometric measures

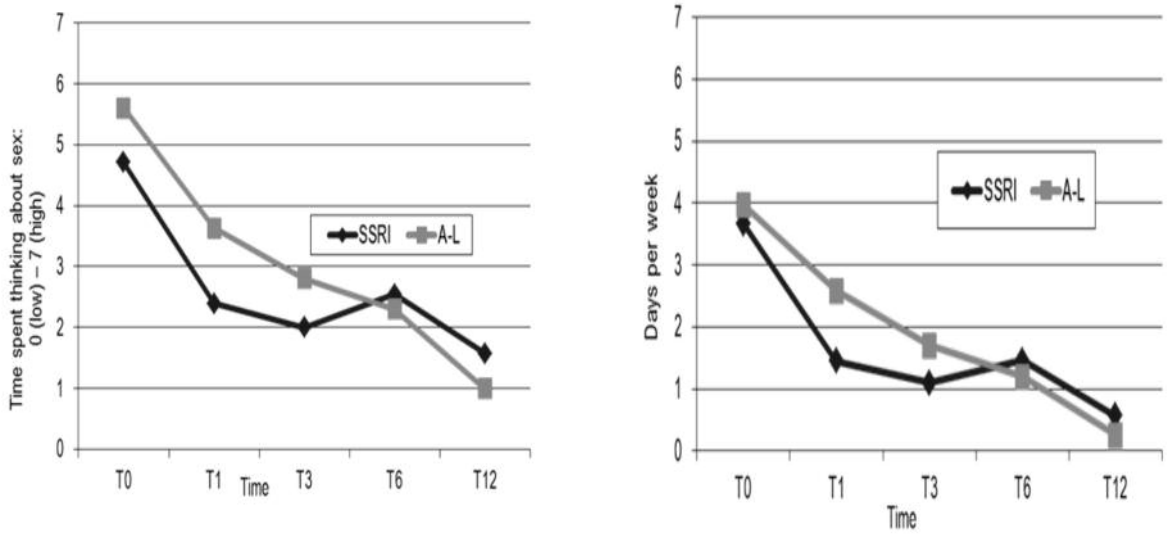
This part of the evaluation primarily focuses on quantitative analysis of individuals who are referred for, and begin to take, medication to reduce their sexual preoccupation (comparisons with those who initially refuse medication, or are non-compliant are also being conducted). Data collated includes: referral information, demographic and offending information, prison file data (e.g. risk levels), and data from participants' medical files (e.g. medication, dosage, health and monitoring information collected on a regular basis). A number of psychometric scales and measures were also collected for individuals referred since August 2011. Psychometric scales are questionnaires or assessments that can be used to measure knowledge, attitudes and personality traits. For this research, the Multi-phasic Sex Inventory (MSI)[31], the Personality Assessment Inventory (PAI)[32], the Sexual Compulsivity Scale (SCS)[33], the Hospital Anxiety and Depression Scale (HADS)[34] and the SIPP-118 (Severity Indices of Personality Problems)[35] are being used.

To date, participants comprise 64 male convicted sexual offenders; average IQ for the sample was 85, a low average score with a range from 63 (extremely low) to 114 (high average). In terms of ethnicity, 56 participants were White British, one was White Other, with data still being sought for seven participants. The average age was 43, within a range of 24-73. In terms of previous offences, over 90 per cent have committed child sexual offences, with an average of five previous contact offences and two previous non-contact offences per offender. The participants had a range of recall, determinate, life and IPP sentences. Of the 64 men referred for the treatment, 36 received SSRIs (Fluoxetine), five received Anti-androgen (CPA), seven received a combination of SSRIs and Anti-androgen, one received a GnRH agonist (Triptorelin), ten did not receive any (refused/not suitable) and five are on hold or under assessment.

Results and discussion

Analysis of the clinical measures demonstrated a reduction across all measures of sexual preoccupation and hypersexuality, including, for example, number of days masturbated per week; strength of sexual urges; time spent thinking about sex and sexual excitability. The graphs below show how participants' sexual preoccupation/hypersexuality reduced between T0

Figures 1 and 2: Time spent thinking about sex and number of days per week masturbated to orgasm for both medication groups, from T0 (prior to medication) to T12 (approximately 12 months after beginning medication)



31. Nichols, H.R., & Molinder, I. (1984). Multiphasic Sex Inventory manual. Tacoma, WA: Author.
32. Morey, L.C.(1991). Personality Assessment Inventory. doi: 10.1037/t03903-000
33. Kalichman, S.C., Johnson, J.R., Adair, V., Rompa, D., Multhauf, K., & Kelly, J.A. (1994). Sexual Compulsivity Scale. doi: 10.1037/t04027-000
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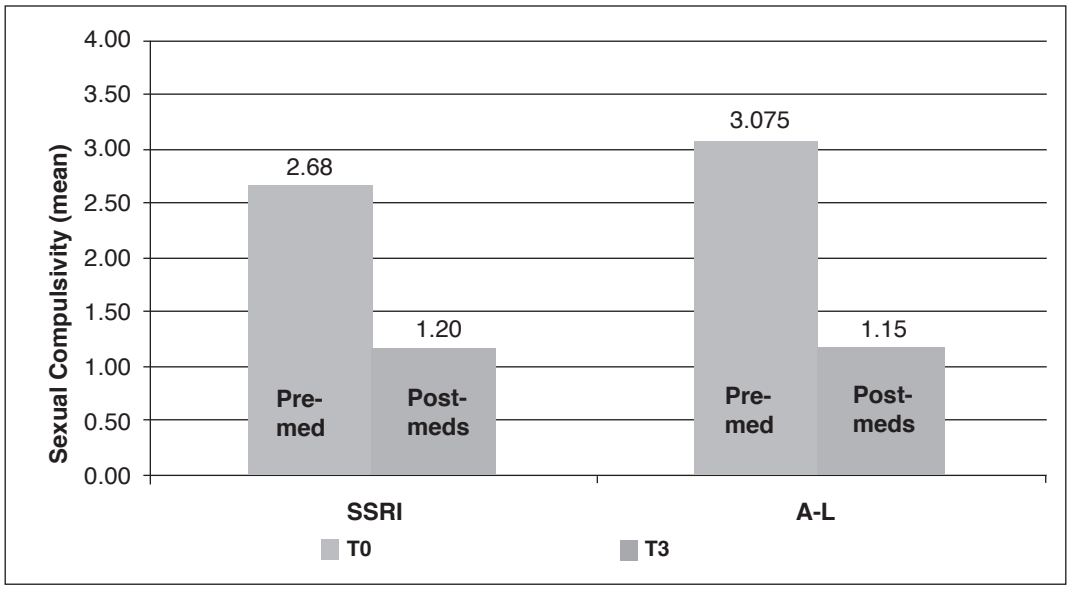
35. Verheul, R., Andrea, H., Berghout, C.C., Dolan, C., Busschbach, J.V., van der Kroft, P.A., & Fonagy, P. (2008). Severe Indices of Personality Problems. doi: 10.1037/t03672-000

Figure 3:
Comparison of pre and post sexual compulsivity scores for both medication groups.



(time prior to taking medications), T1 (approximately one month after taking medication), T3 (approximately three months post medication), T6 (approximately six months post medication) and T12 (approximately twelve months post medication).

Psychometric measures

The MSI was specifically developed for adult sexual offenders and consists of 20 scales measuring sexual deviance, atypical sexual behaviours, sexual dysfunction, sexual knowledge and attitudes. The PAI is a self-report measure providing a static screening of the psychopathology of clients. It consists of 22 scales designed to measure clinical, treatment and interpersonal factors related to personality. Preliminary findings show differences in levels of sexual obsessions can be predicted by levels of anxiety, anxiety-related disorders and depression.

The SCS is a ten item scale designed to measure hypersexuality and sexual addiction. Findings demonstrate that a general sample of sexual offenders have significantly lower sexual compulsivity scores than the medication sample prior to beginning medication. Post-medication, the general sample of sexual offenders had significantly higher sexual compulsivity scores than those on medication. Figure 3 highlights the reduction in sexual compulsivity scores for the two medication groups between T0 (prior to medication) and T3 (3 months after starting medication).

Conclusions

These findings show both types of medication significantly reduce hypersexuality and sexual preoccupation in participants to a level lower than that of the average sexual offender at HMP Whatton. The data merits more fine-grained analysis, however the findings are extremely positive and consistent across the different measures. Further analysis is ongoing.

Part 2:
Service user perspectives

This qualitative study involved conducting interviews (23) with 13 offenders at HMP Whatton in order to explore the experiences and understanding of individuals taking SSRIs. Thematic analysis was implemented because it aims to give voice to the service user while allowing the researcher to add a layer of psychological analysis to the account and experiences of participants. Emphasis was placed on clinical themes relevant to the evaluation and three broad themes emerged: Effects; Participant understanding and concerns; Compliance and engagement.

Effects

This theme details the observed effects of the medication across four different areas:

Sexual preoccupation and arousal — When discussing the impact of the medication, all participants reported a decrease in sexual thoughts and fantasies, suggesting it had 'lessened them to almost nothing most of the time' (Joshua). In turn this resulted in a reduction in the frequency of masturbation:

> *Well since taking it I'm erm not so preoccupied with sexual thoughts erm and*

everything else that goes with sexual thoughts has calmed down as well so masturbation and stuff like that and that's all calmed down (Mohammed)

In comparison with sexual thoughts experienced prior to the medication, participants report the current thoughts and fantasies to be less intense and 'a lot more manageable and more controllable' (Mohammed). The data also highlighted the physical effects the medication was having on arousal for the majority of participants (10). The reported effects include: an inability to achieve or maintain an erection: *'I can get a bit of an erection but I can't get a full erection'* (Tom); an inability to ejaculate or difficulty reaching ejaculation: '*…it just goes on and on and on and I won't ejaculate and I'll just give up on it'* (Mohammed); and / or a reduction in the amount of semen if ejaculation occurs: *'There was hardly anything there at all and sometimes there was nothing there at all…although I ejaculated er it was, I suppose you could call it a dry ejaculation'* (Neil). Previous research has also reported similar adverse effects of SSRIs[31]. For some reason these effects were easily accepted while others attempted to counteract these effects through becoming non-compliant or altering the nature of their fantasies.

Depressive symptoms — Participants who reported difficulties with depression reported improvements since beginning medication. This was something they spoke about very positively, often comparing themselves to previous situations: '*I used to get depressed quite a bit erm but now I sort of hardly have at all'* (Joshua); *'I don't get down as much now and I'm always having a laugh and a joke'* (Nathan). As Nathan highlights, some participants felt this reduction in depressive symptoms had allowed them to become generally *'more communicative'* (Barry) and sociable.

Impulse and emotional control — Participants conveyed their need to respond and masturbate to all the sexual thoughts they experienced prior to the medication in order to *'get the thoughts out of my head…relieve it more than anything else'* (Mohammed). In contrast, individuals now reported increased ability to recognise inappropriate sexual thoughts and urges, and deliberately distract from them:

I mean because I'm not fantasising so much that I'm concentrating more and I can think more about the offenses an er so I know that when these come into my mind …I can sort of helps help to push it away (Joshua)

This allows them to 'choose' the stimuli for arousal and masturbation, in turn altering the nature of the fantasies they experience to become more appropriate. Participants often attribute these changes to the general reduction in sexual preoccupation and having more head space to process thoughts and make conscious decisions. In addition, participants also report improved concentration levels and increased ability to manage their emotions when previously they would become angry or frustrated. This is emphasised in descriptions of themselves as 'more patient' (Joshua) and *'more mellowed'* (Nathan).

On the whole participants possessed a good understanding of the medication and why they were taking it. Their knowledge was gained through discussions with staff, the referral process and reading about the medication.

Side-effects — The majority of participants (11) reported at least one adverse effect of the medication, including constipation, sweating, headaches, tiredness and nausea. In a small number of cases participants became distressed or found the effects unmanageable, however the majority reported them to be short-lived.

Participant understanding and concerns

On the whole participants possessed a good understanding of the medication and why they were taking it. Their knowledge was gained through discussions with staff, the referral process and reading about the medication.

Participants appear to have experienced a number of concerns throughout the course of taking the medication. Initially this was regarding the impact of

36. See n.30.

the medication, what to expect and any side-effects they may experience:

> *Erm I always do, I, any treatment we are doing or any medication I always, I suppose get worried about you know, side-effects, you know, is it going to work? Is it going to make things worse? (Scott)*

Other concerns were expressed regarding the impact of medication on their ability to engage in future sexual relationships, a fear of becoming dependant on it or that it will stop working. The therapeutic relationship between individuals and staff appears vital in providing participants with a safe environment to voice and discuss their concerns: *'we discussed the other options so I wasn't afraid to, you know, to come forward and say that's not happening'* (Scott). It also provides the opportunity to ask questions that allow them to make informed decisions about the medication.

Compliance and engagement

Generally, the level of compliance within the sample appeared high, with individuals presenting as engaged and motivated to take medication. However, some non-compliance was apparent as a method of overcoming the effects on arousal, side-effects or believing that the medication was not working or they no longer need it. Interestingly all individuals who stopped the medication for these reasons later requested to resume treatment. In terms of future plans, participants displayed uncertainty regarding their intentions to keep taking the medication after release, based on a lack of motivation, fear of becoming dependant on it or concerns regarding future relationships.

Conclusions

This research supports the view that medical treatment can be effective in aiding the management and treatment of sexual risk factors such as sexual preoccupation when psychological treatments may be problematic. Despite some concerns and side-effects, the use of SSRIs appears to have had a positive effect in reducing the level of sexual preoccupation and associated sexual behaviours. Other apparent positive changes included increased emotional control and mood enhancement. All participants who experienced psychological treatment programmes emphasised that they did not see medical treatment as a replacement for psychological treatment but felt they worked well together. Overall, participants felt positive about the impact the medication is having: *'I think it's one of the best steps I made'* (Nathan).

Despite some concerns and side-effects, the use of SSRIs appears to have had a positive effect in reducing the level of sexual preoccupation and associated sexual behaviours.

Part 3: Staff perspectives

This qualitative study conducted interviews with eight members of a multidisciplinary team working on psychological intervention with sexual offenders, of whom some were voluntarily taking SSRIs or Anti-androgens to reduce sexual preoccupation. Due to their close involvement with offenders treatment progression and the medication procedures, staff were expected to have detailed and insightful views and, therefore, to add a new dimension to the current literature and inform future research and treatment. A thematic analysis was used and five broad themes were identified which are discussed below: Offenders reluctance to take anti-libidinals; Lack of awareness; Pharmacology: 'Just another piece of the puzzle'; Reporting the self-report: effects of and need for anti-libidinals; and Intellectual disabled offenders.

Offenders' reluctance to take anti-libidinals

Participants explained that offenders' reluctance to take medication is often related to concerns about the impact and side-effects, and a lack of awareness of the medication or of their need for it. It appeared that this was due to rumours circulating, possibly as a result of ambiguity and lack of available information. Making information on medication more accessible should prevent the spread of false or exaggerated rumours and reduce anxiety among offenders. In addition, informing offenders of all the possible implications of the medication should help to instil confidence in the treatment. Participants also indicated that some offenders were reluctant to disclose their sexual preoccupation and need for medication because of fear of adverse implications to their perceived risk level. This highlights the importance of focusing on overcoming poor problem recognition and informing offenders of the benefits of revealing their risk.

Lack of awareness

Participants repeatedly expressed concern about their own and others lack of awareness regarding aspects of the medication process. They discussed a desire to have more feedback following referrals, informing them who has gone onto medication to promote information sharing and end-to-end offender management. Participants also discussed a need for those outside psychology to have increased involvement in the pharmacological treatment process, particularly through completing referrals. It was highlighted that members of staff such as officers may identify a need for medication much earlier, due to their daily contact with offenders. This could be through observing behaviours or offenders confiding in them. Thus, this theme highlights the need for more training with officers and others outside psychology to increase confidence and awareness of the processes.

Pharmacology: 'Just another piece of the puzzle'

Participants discussed their positive view of the medication as a treatment option. However, they also strongly emphasised that medication should not be viewed as a 'cure' or something which can work alone as *'it's just another piece of the puzzle really to kind of help the guys make some of the changes that they need to*' (Tony). In light of this, participants emphasised the importance of having psychological treatment alongside, which is widely accepted[37]. They also expressed the importance of offenders taking responsibility for their treatment and sufficient support being provided after release to encourage its continuation, particularly as staff highlighted motivation to continue medication often decreases on release. This requires the collaboration of all those involved in an offender's sentence.

Reporting the self-report: Effects of and need for anti-libidinals

One of the primary aims of this research was to provide a new perspective into the effects of the medication. However, staff's reliance on offenders self-report to identify a need for medication, or understand how the medication was working became clear very early on. Nevertheless, this in itself is an interesting finding and is possibly a consequence of staff's lack of awareness of who is on medication, emphasising the importance of providing feedback by increasing communication between departments. Despite the reports being secondary, they were largely positive, describing offenders improvements since being on medication, for example: *'He basically would say he could still see the triggers, he just didn't have that sexual desire towards them anymore'* (Tony)', 'One of them referred to it as like a volume button being turned down a little bit' (Jo).

. . . staff's reliance on offenders self-report to identify a need for medication, or understand how the medication was working became clear very early on. Nevertheless, this in itself is an interesting finding . . .

Intellectually disabled offenders

This final theme highlighted participants' discussion of Intellectually Disabled (ID) offenders. They felt that ID offenders *'are overrepresented in the anti-libidinal population'* (Ashley). Participants expressed concern over some of the ethical issues of gaining consent and monitoring progress with this population. They suggest more training for staff, and adapted information and support for offenders, would be useful. Nevertheless, there was still a positive view from participants about ID offenders on medication: *'they had a good awareness of what it's [medication] doing for them'* (Ashley).

Conclusions

The findings of this research highlighted areas for improvement as well as of good practice in the pharmacological intervention. An over-arching theme within the data was the need for more information sharing and collaboration, to encourage end-to-end offender management. Adopting this multidisciplinary approach will contribute to a more successful delivery of the pharmacological treatment, which adheres to NOMS aims of crime reduction, public protection and offender reform[38]. However, there was a positive attitude towards the pharmacological treatment among all staff involved

37. Guay, D.R.P. (2009). Drug treatment of paraphilic and nonparaphilic sexual disorders. *Clinical Therapeutics*, 31(1), 1-31.
38. Turley, C., Ludford, H., Callanan, M., & Barnard, M. (2011). Delivering the NOMS offender management model: Practitioner views from the offender management community cohort study. *Ministry of Justice Research Series 7/11*.

in this research, which demonstrated a general desire to continue to promote it.

Conclusions

The implementation of this service at HMP Whatton appears to have been successful, with 49 prisoners having received treatment to date and more being referred on a regular basis. Furthermore, the qualitative research highlights that the treatment is being received positively by both offenders/service users and staff.

In terms of the treatment's success, preliminary findings are extremely encouraging in that the medication (both SSRIs and anti-androgens) has been shown to significantly reduce sexual compulsivity, preoccupation and hypersexuality based on the quantitative findings. The accounts of both service users and staff support these findings. One of the strengths of the evaluation is that it combines a numerical analysis of sexual and psychometric measures with a broader analysis of the 'big picture' through exploring the thoughts and experiences of service users and staff. The two qualitative studies presented complimentary data highlighting similar findings from different perspectives, for example service user concerns and how to overcome these, which strengthens the validity of the points being made.

In response to some of these findings, HMP Whatton is developing training packages on this service for various staff groups. The prison is dedicated to increasing knowledge and confidence among staff to provide a high quality service of offender rehabilitation. This is just one example of how Whatton strives to achieve offender reform by focusing on individual needs of staff and offenders, and by responding to the complicated risk factors associated with sexual offenders.