63
Sexual abuse of children

by

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Scott Harden

Scott is a psychiatrist with interests and practice in child, adolescent and adult forensic and clinical psychiatry. He has been in private clinical practice since 2000 with particular clinical interests in attention deficit hyperactivity disorder and anxiety disorders. He has a busy private forensic and medico-legal psychiatric practice with cases in the family court, criminal, child protection, juvenile justice, civil and "dangerous" sex offender areas of practice.

He works in the public sector as Medical Director Forensic Child and Youth Mental Health Service, Child and Youth Mental Health Service, Children's Health Queensland providing services to two thirds of Queensland.

He also sits on Medical Assessment Tribunals for the Queensland workers compensation regulatory authority and sits as an Assisting Psychiatrist on The Queensland Mental Health Court.

Scott has developed a preoccupation with advancing the specialised area of child and adolescent forensic mental health within Australia and New Zealand. To this end he has run conferences in this area in 2009, 2011, 2016 and 2017 and is the inaugural chair of the Section of Child and Adolescent Forensic Psychiatry of the Royal Australian and New Zealand College of Psychiatrists.

He has also run courses in association with the Queensland Bar Association for psychiatrists and barristers and been an invited Speaker for the Queensland Law Society and the Queensland Family Law Practitioners Association. He runs two peer review groups for psychiatrists, one in forensic child and adolescent psychiatry and the other for psychiatrists involved in the assessment of individuals under the "dangerous" sex offenders legislation. He was a founding member of the Child Protection Practitioners Association of Queensland.

Scott has interests in quality and safety, particularly with regard to medico-legal reporting and the court evidence of experts, organisational governance and sexual behaviour across the human lifespan. He has some involvement in research.

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She was the founding Chair of Perinatal and Infant Psychiatry at the University of Newcastle and the previous Director of the New South Wales Institute of Psychiatry. In January 2011 she was appointed as a Member of the Order of Australia for work in child protection.

She is a practising infant psychiatrist with expertise in the area of disorders of early parenting and attachment difficulties in infants. She has undertaken research into the issues confronting parents with histories of early trauma and neglect. Her current research focuses on the evaluation of infant-parent interventions in high-risk populations, the concept of parental reflective functioning in mothers with borderline personality disorder and the neurobiology of parenting disturbance.

She was recently awarded grants for intervention studies in Domestic Violence, and she has published in the areas of infant mental health, attachment disorders trauma and prevention of child abuse.

She is the Convenor of the Asylum Seeker Advocacy Group. She has been a government advisor on asylum seeker and refugee mental health and contributed to the development of policy for mental health screening and response to torture survivors. She has been involved in research into the impact of immigration detention on child asylum seekers.

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INTRODUCTION

[63.100] Introduction

When legal practitioners and judicial decision-makers encounter individuals in the legal system who have committed sexual offences against children they are eager for data and expert opinion that helps them to answer critical questions. These questions are:

- What chance is there that this person will commit a further sexual offence against children?
- Who can accurately assess this risk?
- Can sex offenders be treated or can the risk they pose change? And,
- Are there people who will not improve and who will remain a high risk to the community?

Unsurprisingly these straightforward questions remain difficult to answer. There is much research regarding people who commit sex offences against children; however, results can appear (or be) contradictory and require interpretation.

A surprising fact for those new to the field is that individuals who commit sexual offences against children do not necessarily have a sexual preference for children. Moreover, not all paedophiles (individuals with a sexual preference for prepubertal children) have perpetrated sexual acts on children. The distinction between paedophilic and non-paedophilic child sexual offenders is important as they not only differ in their level of risk of reoffending in the future but also the role of a sexual preference for children has implications for treatment interventions and management strategies to prevent further sexual offences (Seto, 2008). Both types are described below, followed by information on other special subgroups of child sex offenders, including women, the clergy, adolescents, the elderly, the intellectually impaired and those convicted of internet child pornography offences.

This chapter will then describe issues around the qualification of experts to assess and treat such individuals and lastly some issues arising in particular legal contexts such as ongoing detention following completion of sentence, allegations of child sexual abuse in the family court, and applications for damages in civil court proceedings.

This area of practice is bedevilled by issues of terminology but so far as practicable we will use terms in a scientifically or clinically applicable sense.

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PAEDOPHILIC CHILD SEX OFFENDERS

[63.200] Overview

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, 2013) (DSM V) defines Paedophilic Disorder as "recurrent intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children (generally 13 years of age or younger) in a person over 16 and at least five years older" over a six-month period. This manual differentiates this from paedophilia sexual orientation on the basis of functional impairment composed of distress at or acting on such urges. Hebephilia refers to a sexual preference for those in the early stages of puberty, and while in some cases this may be biologically normative it is still considered as requiring intervention. In Australia, one cannot be charged with paedophilia (or hebephilia), as it is only perpetrating a sexual act against a child that results in prosecution and conviction. As the majority of convicted child sex offenders are male, the following section has been limited to male offenders. For information specific to female child sex offenders, please refer to the relevant section under "Special Populations".

[63.220] Aetiological theories

Why are some adults sexually attracted to children? Seto, an acknowledged leader in the field, outlines three possible aetiological factors that attempt to describe the development of paedophilia – conditioning, childhood sexual abuse and neurodevelopmental perturbations (2008).

Conditioning

While most people adjust their sexual preference for similar aged peers as they develop throughout adolescence and adulthood a small number of people may pair sexual gratification during early sexual experiences with the specific physical attributes of their early sexual partners (such as small body size, an absence of pubic hair, etc) and remain sexually aroused to children despite their own development over time (Seto, 2008). As a consequence, deviant sexual fantasies may develop. It remains unclear why these people associate the pleasant sexual experiences specifically with children or their physical attributes, although some suggest previous history of childhood sexual abuse (Ryan et al, 1996) and poor parent attachments/loss of parenting figures (Rich, 2006) as possible contributors.

Research has found that sexual offences against children are often accompanied by deviant sexual fantasies (Marshall et al, 1991) and that an increase in sexual arousal can be paired with

non-sexual stimuli (as occurs in conditioning theory) (Lalumiere and Quinsey, 1998). However, the effect sizes of these studies are small, suggesting that while conditioning (rewards and consequences changing frequency of behaviour) may play a role in the development of paedophilic tendencies, it is unlikely that this is the only factor involved.

Childhood sexual abuse

Research suggests that paedophilic sex offenders are more likely to have experienced sexual abuse as a child than other sex offenders (Connolly and Woollons, 2008; Jesperson et al, 2009). The over-representation of sexual abuse experiences among paedophiles has also been used to explain why male victims are more likely to be targeted (Seto, 2008b). However, most victims of sexual abuse do not go on to commit sexual offences against children, suggesting that other factors, perhaps interpersonal differences amongst victims or other aspects of the early abuse play a role in predicting who will sexually offend (Burton et al, 2002; Seto, 2008).

Neurodevelopmental Disorder

It has also been suggested that problems in brain functioning could explain the development of paedophilia (Seto, 2008). Blanchard et al (2003) reported that sex offenders were more likely to experience head injuries before the age of 13 and Cantor et al (2005) found differences on measures of intelligence among child sex offenders. Areas of the brain that may be related to the development of sexual preference include the frontal lobe (associated with executive functioning) and temporal lobe (often associated with emotional processing and regulation of sexual behaviour) (Seto 2008b). Results in general though have been mixed and there is no conclusive evidence that neurological differences between paedophilic and non-paedophilic sex offenders can explain child sex abuse (Seto, 2008).

If future research can demonstrate neurological difference between paedophiles, other offenders and non-offenders, then questions around causality are likely to arise, for example, whether paedophilic tendencies change brain structures or if the abnormalities in brain functioning contribute to the development of paedophilia.

[63.240] Descriptive characteristics

The prevalence of paedophilia in the general population is unknown, as studies investigating this would need to measure the persistence and intensity of sexual thoughts, fantasies, urges, arousal or behaviour involving children (Seto, 2008). Some studies have attempted to do this; however, they often include everyone who has had a thought of sexual contact with a child (a much lower hurdle than meeting diagnostic criteria for paedophilia) and therefore did not examine the persistence and intensity of these thoughts required for such a diagnosis. As such, these studies can only provide **upper** limit estimates regarding prevalence (Seto, 2008).

In studying 193 male university students, Briere and Runtz (1989) found that 9% had fantasised about having sex with a prepubescent child. Of the participants, 7% indicated some likelihood of having sex with a child if they were guaranteed that they would not be punished or identified and 5% reported that they had masturbated to fantasies of sex with children. These results are consistent across studies using student samples (Fromuth et al, 1991; Smith, 1994).

Using members of the general community, research has generally found that heterosexual men exhibit some sexual arousal to prepubescent girls; however, this rate was less than the rate of arousal towards pubescent girls and adult females. There was less sexual arousal to male stimuli (Seto, 2008). The DSM-V states that the highest possible prevalence is 3%–5% of the male population.

[63.260] Assessment

The aim of a risk assessment in this area is to identify the presence or absence of a sexual preference for children in a person who has committed a sexual offence against a child (Camilleri and Quinsey, 2003) and also to identify other factors that increase the likelihood of recidivism so that an effective intervention strategy can be developed (Craig et al, 2008). It is important to keep in mind that conceptually, "high risk" in these assessments does not usually correlate with "level of dangerousness" which refers to the severity of behaviour as opposed to likelihood of re-offending. There are three essential approaches to conducting a risk assessment which are outlined below: the Unstructured Clinical, the Actuarial and the Structured Professional Judgements. In 1998, Hanson and Bussiere's meta-analysis on predicting recidivism found that clinicians using the Unstructured Clinical approach to predicting recidivism perform slightly better than chance. The clinical judgement approach to risk assessment is considered as less accurate than both the structured clinical judgement and the actuarial approaches. However, while a recent meta-review by Singh and Fazel (2010) suggests that the actuarial assessment approaches are more accurate than structured clinical judgements, it is not uncommon for clinicians to use a combination of these as the purpose of an assessment is not only to predict risk, but to make appropriate treatment intervention strategies and management plans.

Unstructured Clinical Judgements

Traditional unstructured clinical judgements are the result of a clinicians' assessment of a particular individual on the basis of their clinical experiences and professional judgement. The benefit of utilising an unstructured clinical judgement approach is that it is flexible and allows the assessor to consider case-specific factors as they apply to the individual case (Doyle and Dolan, 2002). However, there are three major issues in utilising this approach which makes this method undesirable. First, it tends to lack internal consistency, as different clinicians apply different knowledge and experiences to the individual cases. Second, it is unclear as to how the final decision regarding risk is reached, making it hard to question/validate the factors taken into consideration during the assessment. Finally, research has found that with regards to accurately predicting recidivism, this method performs at equal to or just above chance levels (Hart, 1998). However, Boer (2008) reports that the accuracy of unstructured clinical judgements continues to improve and is likely to be associated with ongoing research and an increase in general understanding about this population, although one can argue that this increase in knowledge tends to effectively make such unstructured assessment of risk more similar to structured professional judgement approaches.

Actuarial Risk Assessment

Actuarial risk assessments are considered a more mechanical approach as offenders are placed in certain risk categories based on scores using a predetermined set of empirically validated factors shown to be correlated with recidivism in follow-up studies. As the factors used to determine risk categories are empirically validated, they are considered to result in greater predictive accuracy than unstructured clinical judgements (Doyle and Dolan, 2002). However, there are some problems in utilising this approach, as summarised by Hart (1998). Firstly, this approach concentrates on a limited number of risk factors and, as such, may ignore potentially crucial factors relevant to the individual, as these may not have been measured in the study population(s). There is also a considerable focus on static or historical risk factors, which are not amenable to change and perhaps add little to the development of management plans over time. Furthermore, while the factors utilised in these measures have been empirically supported, the results of these studies have been collapsed over large numbers of participants and the degree to which these results can be generalised to individual offenders can bring into question the validity of these items.

No instrument is perfect. Psychometric tests are prone to Type I and Type II errors (terms used to describe particular statistical flaws in which an actual outcome, that is, this person poses little risk, was incorrectly rejected or endorsed), and results are often summarised for a large sample of offenders, which collapsed, may not necessarily reflect the particular "real world" offender in front of us. Below is a summary of actuarial tools that are commonly used in sex offender risk assessments:

- Sex Offender Risk Appraisal Guide (SORAG)

  The SORAG uses 14 items to predict violent and sexually violent recidivism among adult males who have committed a sexual offence involving physical contact. The SORAG contains all 10 items of its sister tool, the Violence Risk Appraisal Guide (VRAG), with an additional 4 items specifically related to sexual offending (Vincent et al, 2009). To complete the SORAG, the assessor needs to be a qualified examiner, particularly considering that one of the items on this measure relates to a score obtained on the Psychopathy Checklist – Revised (PCL-R; Hare, 2003) which needs to be administered by a trained professional.

  Items on the SORAG have varying low- to high-risk scale ranges and are summed to provide an overall risk score, which falls into 1 of 9 categories and provides an estimated probability of recidivism. Recidivism estimations range from 9% to 99% and predict the likelihood of another violent or sexually violent offence occurring without (as is for most risk assessment measures) predicting the severity of the future offence. The SORAG has been tested using a number of samples (North American primarily), including incarcerated sex offenders, sex offenders in residential treatment programs and non-incarcerated offenders referred to an outpatient treatment program (Vincent et al, 2009). Although most studies have found the SORAG to be a relatively accurate predictor of recidivism, particularly when assessing child molesters, it is considered to be better at predicting general violent behaviour as opposed to sexual recidivism (Ducro and Pham 2006).

  ROC (Receiver Operating Characteristic) is a statistical procedure often used to describe the accuracy of the measure and can be considered the trade-off between false negatives and false positives. Scores close to 1 using ROC Curve analyses indicate that the test is perfectly able to accurately distinguish two groups (ie, recidivists from non-recidivists) whereas scores close or equal to 0.5 suggest difficulty distinguishing between groups and is considered a poorer performing test. Harris, Rice and Quinsey (2010) report that the median ROC area for the prediction of violent recidivism is 0.72 for the VRAG and 0.73 for the SORAG and were considered by the authors to exhibit large predictive effects.

- Rapid Risk Assessment for Sexual Offence Recidivism (RRASOR)

  The RRASOR, the shortest actuarial measure, consists of only 4 items and was designed to predict recidivism amongst men who have had a previous conviction for a sexual offence (Hanson, 1997). The items on this measure target historical or static risk factors, including whether or not there have been prior convictions for sexual offences, the age of the offender, whether or not male victims were targeted and whether or not the victim/s were related to the offender. Each score on the items is summed to provide a total score, ranging from 0 to 6, with greater scores representing a greater risk of recidivism. The authors of this measure do not specify whether or not those administering the test need to have specific qualifications. Tests have shown that the RRASOR correlates well with other tools known to predict violent recidivism and

sexual offending and is considered to be a fair predictor of risk for both adult rapists and child molesters (Vincent et al, 2009).

Hanson (1997), across seven developmental samples using 2, 592 sexual offenders, found that RRASOR scores had an average correlation of 0.27 with sexual recidivism, with an average AUC of 0.71, ranging from 0.62 to 0.67. AUC scores are generated from a statistical formula used to measure discrimination or the percentage that the test can correctly classify two random samples from alternative outcomes of the test (eg, low risk, high risk). Although there are no specific cut-offs as to what makes a good AUC score, scores obtained by Hanson would be considered to be "fair".

- Static-99/Static-2002/Revised

The widely used Static-99, Static-99R, Static-2002 and Static-2002R have been designed to measure the long-term risk of recidivism for violent and sexual offenders among males who have been convicted of a sexual offence against a child or a non-consenting adult (Vincent et al, 2009). Like the RRASOR, the items on this measure were chosen on the basis of the empirical evidence that suggested that they were the strongest predictors of recidivism. Similar to the RRASOR, the Static versions use historical risk factors to predict recidivism and can therefore be conducted without a clinical interview. It is recommended that the assessment measure be conducted by an experienced evaluator such as police officers, researchers and psychologists. Total scores vary depending on the variant used and based on this, individuals are placed into risk categories, with greater scores indicating greater levels of risk (Seto, 2008). The Static variants have been extensively tested with regards to their predictive ability with a number of different populations (in North America and Europe), including those convicted of a sex offence, those evaluated at an outpatient behaviour clinic and those at forensic psychiatric facilities. Across these studies, both the Static-99 and the Static-2002 were able to adequately predict both sexual recidivism and serious and violent recidivism, with the Static-2002 showing a slight improvement in these (Vincent et al, 2009). The Static-99 was found to have moderate predictive validity (AUC = 0.62) (Bengston and Lanstrom, 2007). The predictive accuracy of the Static 2002 was examined over eight samples of sex offenders in over five countries by Hanson, Helmus and Thornton (2010). They obtained AUC scores of .68, .71 and .70 when using the measure to predict sexual, violent and general offending, respectively. The most recent guidelines in the stable of the static variants are the 2016 coding rules for the static 99R (Phenix et al, 2016).

The Static variants are associated with the dynamic measure the STABLE 2007 and the acute risk measure the ACUTE 2007. The Stable 2007 (originally STABLE 2000) is an empirically derived tool for assessing dynamic factors that may be relevant to sexual offending recidivism and are susceptible to change over a 12-month period or greater. This tool is predominantly used for planning treatment activities and for looking at treatment needs but it also provides information that may be relevant to dynamic recidivism risks. The tool was further refined in the 2007 edition to increase its reliability.

- Sex Offender Need Assessment Rating (SONAR)

The 9-item SONAR is a tool that was developed not only to assess risk of recidivism in sexual offenders but also to assess the change in this risk over time (Hanson and Harris, 2000). The SONAR is considered the only actuarial instrument that incorporates dynamic or changeable risk factors (Vincent et al, 2009). Like the

aforementioned measures, the items on this measure target empirically validated risk factors and include five relatively stable factors (including Intimacy Deficits, Negative Social Influences, Attitudes Tolerant of Sex Offending, Sexual Self-Regulation and General Self-Regulation) scored between 0 and 2. The SONAR also includes four acute factors (Substance Abuse, Negative Mood, Anger, and Victim Access) that are scored from -1 to 1 which are useful when identifying when an offender is more likely to recommit an offence. Total scores on the SONAR range from -4 to 14 over five graded risk categories. The SONAR is considered to have adequate predictive accuracy with regards to sexual recidivism (Hanson and Harris, 2000).

When using ROC scores to measure the predictive properties of the measure, Hanson and Harris (2000) found adequate internal consistency and moderate ability to differentiate recidivists and non-recidivists, obtaining a ROC area of .74.

Structured Professional Judgement tools

Structured Professional Judgements (SPJ) use an evidence-based framework that promotes consistency and structure which remain flexible enough to take into account potentially critical case-specific factors. Assessors use these instruments to guide them in deciding which relevant factors to consider in determining risk levels, before using these to delineate a treatment/ management response (Doyle and Dolan, 2002). The most utilised tool incorporated into Structured Professional Judgement was the sexual violence risk 20 (SVR-20) and more recently the Risk for Sexual Violence Protocol (RSVP), described below. Usually an assessor would use one SPJ tool to structure an assessment.

- Sexual Violence Risk – 20 (SVR-20)

  The SVR-20, developed by Boer, Hart, Kropp and Webster (1997), is a 20-item checklist of factors used in sexual violence risk assessments. It can be (and is often) used in correctional settings to determine suitability to set conditions for release as well as assist in the development of post release treatment or management plans. falling into three categories: Psychosocial Adjustment, History of Sexual Offending and Future Plans. The SVR-20 items address both static and dynamic factors relevant to violent recidivism. The items are coded, based on the presence (Yes or No) of factors and if a factor is present, whether there has been a change in that factor (Exacerbation, No Change, Amelioration). Once completed, the SVR-20 summarises risk into low, moderate or high and although the instrument makes no recommendations regarding the relevant risk levels, it asks the assessor to consider the following five questions:

  1. What is the likelihood that the individual will engage in sexual violence, if no efforts are made to manage the risk?
  2. What is the probable nature, frequency and severity of any future sexual violence?
  3. Who are the likely victims of any future sexual violence?
  4. What steps could be taken to manage the individual's risk for sexual violence?
  5. What circumstances might exacerbate the individual's risk for sexual violence?

  The predictive validity of the SVR-20 is generally considered to be good and research

by de Vogel et al (2004) argued that the SVR-20 is a more accurate predictor than the Static-99. In a meta-analysis comparing the accuracy of a number of different assessment tools, Hanson and Morton-Burgon (2007) found that the SVR-20 was the single strongest predictor of sexual recidivism.

- Risk for Sexual Violence Protocol (RSVP)

  The RSVP (developed by some of the authors involved with the development of the SVR-20) requires the assessor to gather information relating to 22 risk factors split into five categories, including Sexual Violence History, Psychological Adjustment, Mental Disorder, Social Adjustment and Manageability (RSVP; Hart et al, 2003). The RSVP allows assessors to characterise risk in terms of the nature, imminence, severity and frequency while providing a framework around how to manage those risks (Vincent et al, 2009). This measure does not use algorithms to determine the level of risk – this is left up to the discretion of the assessor. The RSVP highlights information relating to the factors associated with risk before having the assessor consider the relevance of these factors and identify possible risk management strategies (Craig et al, 2008).

Additional measures

An area that had also gained interest and research in terms of aiding risk assessment measures/judgements (and treatment interventions) are the use of psychophysiological assessments (Holoyda and Newman, 2016). These primarily include the Penile Plethysmography (PPG), Visual Reaction Time (VRT) and eye tracking technology.

- A penile plethysmograph is usually placed over the penis of the subject and measures physiological changes as they watch/listen to sexually suggestive material. Although not often used in courts in the United States and Canada (and rarely in Australian courts), it is thought to be useful in detecting sexual deviancy, though identified issues call into question the validity and use of the measure. Primarily, some evidence suggests that sexual interest could be concealed or suppressed (Adams et al, 1992; Hall, Proctor and Nelson, 1988) while other research questions whether or not using sexually explicit material using children is ethical (Baker and Howell, 1992).

- VRT refers to the relative amount of time that a subject spends looking at a certain image across a number of images with differing sexual content, subjects and settings (Holoyda and Newman, 2016). The idea behind this test is that the more arousing the image is to the subject, the longer they will spend viewing the image, and information about the image can be used to determine sexual interest.

- Related to this VRT approach is the eye tracking technology that allows examiners to track where the subject looks to within the image, and the area that has received most of the visual attention of the subject can allow the examiners to make hypotheses regarding sexual preference (Hall, Hogue and Guo, 2011). As with the PPG, VRT and eye tracking technologies are not considered robust and reliable, and are not permissible in court (Fromberger et al, 2012).

Advances in medical imaging and technology are also being used to assist in the assessment and treatment planning of sexual offenders. Like the PPG, VRT and eye tracking technologies, medical imaging devices such as the fMRI (functional magnetic resonance imaging) (along with our increasing knowledge about the brain structures these technologies measure) have looked at patterns of activation when the subject is viewing various stimuli – also to determine likely arousal patterns and preferences (Ponseti et al, 2016). There is research studying

differences within the overall brain structure between paedophiles and non-paedophiles as way to support a neurodevelopmental basis for paedophilia (Dyshniku, Murray, Fazio & Lykins, 2015; Peoppl et al, 2013; Gerwinn et al, 2015). However, likely as a result of our continuing lack of clarity in understanding neurobiological mechanisms generally, as well as the aetiology for paedophilia remaining largely unresolved, research results can be largely hypothetical or inconclusive (Mohnke et al, 2014).

[63.280] Treatment

The main focus of treatment for paedophilic child sex offenders is to prevent further incidences of sexual offending (Camilleri and Quinsey, 2003). Treatment and management planning for child sexual offenders has been controversial and continues to be influenced by political concerns. In 2002, Hanson et al conducted a meta-analysis to examine the effectiveness of psychological treatment that included data from 43 studies (using a total of 9, 454 participants). They found that, averaged across all studies, the recidivism rate for treatment groups (12.3%) was lower than that for the comparison groups (16.8%), highlighting the potential benefits of psychological interventions.

History of psychological interventions

Early intervention strategies in the 1970s and earlier had difficulty demonstrating clinical effectiveness and were based on the concept that once sexual interest in deviant acts and objects were reduced, normal sexual arousal patters would arise (Marshall et al, 2009). However, clinicians found that more adaptive and socially acceptable sexual interests did not simply replace deviant sexual arousal patterns during the course of treatment.

Treatments then moved towards including strategies and interventions to improve the offender's skill and ability to function more effectively in a consenting adult relationship, and expanded to include more behaviour-based interventions that targeted cognitive distortions, increasing empathy capacity and social skills training (Marshall and Laws, 2003).

The 1980s saw the inclusion of relapse prevention strategies (commonly used in substance abuse treatment programs) to prepare for the possibility of a relapse and the development of skills to avoid and manage such events. While some researchers such as Marshall and Anderson (2000) doubt the effectiveness of these latter strategies, most programs today incorporate some relapse prevention strategies.

Current treatment approaches reflect the changes in etiological theories of child sex offending. Interventions usually focus on a range of areas, including cognitive distortions, improving the capacity for remorse and empathy, information around healthy sexual practices, exploring the role of intimacy in sexual relationships, social and coping skills training and reducing the sexual attraction to children while increasing sexual arousal to consenting adult relationships. Current treatment interventions tend to explore the nature of the offence(s) in an attempt to identify and to promote insight into the offender's criminogenic needs (Marshall and Anderson, 2000). Most current interventions are specifically targeted towards the offenders' needs/deficits. Research evaluating treatment interventions has demonstrated an increase in treatment efficacy since the 1980s, suggesting more positive outcomes for those who have completed treatment programs (Laws and O'Donohue, 2003; Kielsgard, 2016). Research also suggests that the stigmatizing attitudes (such as a reduction in prejudicial attitudes of those delivering the treatment intervention) may also play a role in the effectiveness of the treatment provided (Jahnke, Philipp and Hoyer, 2015).

Psychological treatment models

- Risk-Needs-Responsivity Model

  According to the Risk-Needs-Responsivity Model (developed by Andrews and Bonta

2003), treatment is most likely to be effective when all the three principles – Risk, Needs and Responsivity – are utilised to guide intervention. The Risk principle suggests that the highest-risk clients should receive more intensive intervention while low-risk offenders receive less as, according to Harkins and Beech (2007), they are less likely to re-offend anyway. The Needs principle is the idea that treatment programs need to be designed specifically to address the individual criminogenic needs of the offender. Thus, the assessment of sex offenders should identify which interpersonal and environmental variables increase the risk of recidivism, so the treatment program can target these specific risk areas. In keeping with the Responsivity principle, treatment is then guided by the specific learning styles and abilities of the individual offender, taking into account any potential barriers to treatment (Craig et al, 2008).

- Good Lives Model

  This model is based on the assumption that providing offenders with the opportunity to improve their lifestyles and developing the skills and pro-social values is likely to result in less offending behaviour (Laws and O'Donohue, 2003).The Goods Lives model is centred on the offender's human needs and aims to enhance their well-being (Ward and Stewart, 2003). This model is now often a component in current treatment programs and is often utilised in combination with the Risk-Needs-Responsivity approach.

- Individual vs Group Programs

  Treatment for sex offenders is usually offered in both group and individual formats, with correctional facilities typically offering group programs. The cited benefits of individual therapy include greater confidentiality and easier modification (eg, to cope with cognitive impairment and allows for those who are less comfortable in group settings to engage more effectively). Conversely, group therapy is often seen as more advantageous practically, as multiple offenders can be treated in a more cost-effective manner. Those participating in group programs also report feeling more supported and can often learn from or be challenged by other participants (Fuhriman and Burlingame, 1990). In some circumstances this is considered to be more effective than being challenged by a professional.

  While research has attempted to determine which is superior, methodological issues make research in this area difficult because of problems controlling for other variables such as medication treatments, other psychological interventions, level of risk amongst offenders in the different programs, intensity of treatment and maintaining comparable treatment foci (Di Fazio et al, 2001). Ware et al (2009) reviewed research comparing treatment modalities and concluded that group treatment approaches were at least as effective as individual treatment and highlighted group processes which could potentially meet other criminogenic needs of the offender (such as those identified previously) more easily than individual formats. Currently in Australia, incarcerated sex offenders are generally encouraged to participate in group programs, either during incarceration or in the community, though they are not mandated to. Varying levels of insight into offending are accepted by different programs with some centres running "deniers" programs that will accept individuals who still deny responsibility for the offence onto specific programs as risk reduction does not seem to be altered by denial (Marshall et al, 2011). Individual interventions can also be offered in addition to participation in the group program; however, these are primarily focussed on supporting the offender's involvement in the group program.

Biological treatments

Medical procedures and medications have been used to target the physiological sexual arousal associated with children in paedophiles. It is important to note that although research has shown a strong relationship between neurobiological variables in sexual behaviour and treatment, this does not mean that medications can be used to change sexual preference. Biological interventions are in general used to reduce sexual drive (Camilleri and Quinsey, 2003). Originally these procedures, often referred to as "chemical castration" or "surgical castration", were used to reduce testosterone levels (medically or by testicular removal) or to place lesions on areas of the brain responsible for sexual functions. Surgical methods are not used in the Australian context.

Two medical approaches are in current use. One targets testosterone reduction via hormonal pathways (medroxyprogesterone, cyproterone acetate and GnRH analogues). This reduction in testosterone is effective in reducing sexual interest and therefore sexual offence recidivism, but the medications are associated with significant side effects in some individuals. These include weight gain, hormonal side effects (such as breast development) and longer term bone-related problems. Newer medications considered in the treatment of sex offenders (such as serotonin reuptake inhibitors) interact with the neurotransmitters associated with sexual functions but have a more limited research base demonstrating efficacy (Bradford, 2001). The research base is so limited that a recent Cochrane meta-analytic review concluded, "It is a concern that, despite treatment being mandated in many jurisdictions, evidence for the effectiveness of pharmacological interventions is so sparse and that no RCTs appear to have been published in two decades. New studies are therefore needed and should include trials with larger sample sizes, of longer duration, evaluating newer medications, and with results stratified according to category of sexual offenders." (Khan et al, 2015).

[63.300] Recidivism

Studies describing recidivism rates amongst child sex offenders typically use official statistics (such as new criminal charges and/or convictions) and as such may underestimate the actual rate of recidivism (Seto 2008). There are a number of factors at each of the different points of reporting, charging and conviction that could all contribute to the possibility of the official re-arrest or conviction rates underestimating the "real" statistics.

An alternative method to relying on official data is administering/utilising self-report measures; however, there are questions about the reliability of such data, as factors such as fear of further conviction and shame may inhibit honest disclosures.

In 1998, Hanson and Bussière reviewed 61 studies examining the rates of recidivism among a combined group of 24, 000 sex offenders. They found that five to six years following the commission of the 9, 603 offences against children, 13% of offenders had re-offended. Twenty-one years after being released from custody, Hanson et al (1993) found that 42% of the 197 sex offenders studied had been convicted of a violent and/or sexual offence. Of these, 23% were considered to have offended 10 or more years after being released. However, it was not known which of these offenders would also meet the diagnostic criteria for paedophilia.

With regards to recidivism amongst paedophiles, rates vary between 10% and 50%. Moulden et al (2009) followed up extra-familial child sexual offenders, who had also been given a diagnosis of paedophilia by a psychiatrist, after being convicted of a sexual offence. They found that after 10 years, 22.8% had been re-convicted of a sexual offence. In comparison, 33.9% of these offenders had been charged with a violent offence and 45.6% had been charged with a non-violent, non-sexual offence.

[The next text page is 63-401]

NON-PAEDOPHILIC CHILD SEX OFFENDERS

[63.400] Overview

Non-paedophilic child sex offenders, often referred to as "situational child sex offenders" or "regressed child sex offenders", do not have a sexual preference for children. These types of child sex offenders may have less deviant primary sexual interests but engage in sexually abusive behaviour with children when a situation exists or develops that makes this possible.

[63.420] Aetiological theories

There have been a number of theories put forward as to why men who prefer sexually mature partners sexually offend against children. Reasons have included dissatisfaction with the offenders current relationship with an adult partner, an inability to attract a more socially acceptable partner (for a variety of reasons, including physical attractiveness, lack of resources, lack of social skills etc) and having a high sex drive (Seto, 2008). According to some researchers, including Landold et al (1995), men re-adjust their sexual behaviour as a function of their access to potential adult partners. Thus, although children and adolescents are not the ideal sexual partner, these offenders may still elicit some sexual arousal to them and may seek them out in the absence of the ideal. As such, the interaction between these types of offenders and their victims can be different from that of the paedophilic child sex offenders. While the paedophilic child sex offenders often interact with the child on the level of the child, non-paedophilic offenders often engage with them as adults, often as a "substitute spouse" (Seto, 2008).

Some have also argued that child sex offences carried out by non-paedophilic perpetrators should be regarded as a reflection of general antisocial tendencies (Seto, 2008). Seto further outlines thinking that there are two main pathways towards antisocial behaviours, one as a result of neurodevelopmental deficits and an adverse early environment and the other to the development of interpersonal traits like psychopathy (see below).

[63.440] Descriptive Statistics

Research estimates that the number of arrested offenders carrying out sexual acts on children who would not be considered to meet the diagnostic criteria for paedophilia, that is, offenders who offend against a child more out of opportunity as opposed to being motivated by a sexual interest in children, is approximately 50% (Seto, 2008). According to Seto and Lalumiere, (2001), non-paedophilic child molesters are more likely to target female victims, single victims, pubescent or post-pubescent victims and unrelated victims.

[63.460] Assessment

The assessment tools described in the prior section have been developed using a number of sex offenders in different contexts. Research guiding the development of these tools often use those convicted of a sexual offence and does not discriminate between those who may or may not meet the diagnostic criteria for paedophilia. As such, the assessment tools in the previous section can be administered to both non-paedophilic and paedophilic child sex offenders.

One important factor to consider in the assessment of sex offenders is psychopathy. Broadly, psychopathy is defined as a short-term, impersonal and antisocial approach to life by those with particular personality characteristics (Hare, 2003). Enduring personality characteristics that are associated with psychopathy include glibness, insincerity, callousness, unempathic, impulsivity, an increased need for stimulation, irresponsibility and persistent and versatile antisocial behaviour. Psychopathic personality characteristics are often defined by an extensive and versatile criminal history and this may include sexual offences against children. As such, there are a number of child sex offenders who are high on psychopathy. However, child sex offenders high on psychopathy are less likely to be considered paedophilic as well (Vitacco and Rogers, 2009). Research has shown that psychopathic sex offenders who carry out offences against children are more likely to target pre-pubescent and pubescent girls and are at a high risk of recidivism generally (Seto, 2008). Psychopathy is generally assessed using the Psychopathy Checklist (PCL-R; Hare, 2003; PCL:YV for juvenile populations) and needs to be carried out by a professional trained in its use. Psychopathy is an important consideration in the sex offender assessment as it plays an important role when developing treatment interventions and considering the risk of recidivism.

[63.480] Treatment

As with the previous section, treatment for the non-paedophilic sex offender mirrors the interventions typically used for paedophilic offenders. This includes a holistic approach that reflects their risk and criminogenic needs. Ideally, treatment would include components that address all aspects of their offending behaviours, not just those related to their sexual offences against children. Bourdin and Schaeffer, (2001) found that psychological treatments that targeted general dynamic risk factors in their programs had a positive impact on both sexual and general recidivism rates.

[63.500] Recidivism

Whether or not an offender is paedophilic or non-paedophilic has important implications on recidivism. Many non-paedophilic child sex offenders have anti-social attitudes and have committed other types of offences in their criminal pasts as well. Their behaviour then is often conceptualised not as sexual deviation per se, but as a result of general antisocial views and/or personality traits. As antisocial traits have been demonstrated to be good predictors of recidivism (Seto, 2008), recidivism rates among non-paedophilic offenders are also higher than those among paedophilic offenders. Rates of recidivism for those high on measures of psychopathy are often higher than those for all other types of offenders. It should be noted, however, that antisocial, as opposed to paedophilic, child sex offenders are more likely to repeat their antisocial behaviour via general antisocial acts and behaviours and may not necessarily reoffend with another child sex offence.

[The next text page is 63-501]

SPECIAL POPULATIONS

[63.600] Females

There is little consistent data at this time. In a study of 546 female university students, Fromuth and Conn, (1997) reported that 4% acknowledged at least one sexual experience with a younger person (at least five years younger). Of these incidents, 92% involved physical contact.

As for convicted offenders, approximately 1% of the adult sex offenders and an estimated 10% of adolescent sex offenders are female (Seto, 2008). For a number of reasons (including gender role stereotypes, a reluctance to disclose abuse to authorities and other socio-cultural factors), the incidence of sexual assault carried out by females is likely to be underestimated (Saradjian, 2010). As the number of female sex offenders who have been tried and convicted is small, concluding research with this population is challenging. Some studies have shown that like their male counterparts, female child sex offenders are more likely to be poorly educated and come from lower socio-economic areas (Crassati, 2004). Also, while some note that like their male counterparts, female sex offenders are more likely to target female victims over males (Lewis and Stanley, 2000), other research has demonstrated males as the more likely victims (Denov, 2003). It was previously thought that women convicted of sex offences were most often accomplices of male partners; however, research reveals a growing number of female sex offenders working alone (Vandiver, 2006; Correctional Services of Canada, 2008).

In a large meta-analysis, Vandiver, (2006) describes the average female sex offender acting alone as a white female in her 20s or 30s, who is likely to have a history of physical and/or sexual abuse with an alcohol/substance use problem. Those acting as an accomplice to a male sex offender are described as more likely to be in a sexual relationship with the male abuser and living with them at the time of offence. The relationship between co-offenders is likely to be abusive. Women acting as accomplices, compared to female sex offenders acting alone, are more likely to have multiple young victims, are more likely to victimise both females and males (as opposed to males alone) and have often been charged with a non-sexual offence at the time of the sexual offending.

The paucity of information examining sex offences perpetrated by females makes it difficult to develop well-formulated theories regarding female sexual offences against children and how they differ from their male counterparts (Correctional Services of Canada, 2008). One theory, developed by Matthews et al (1989) based on clinical observations, divides adult female sex offenders into three categories based on their motivations for offending. Vandiver and Kercher, (2004) employed a statistical approach towards creating a typology using 450 female sex

offenders. Their analyses revealed six subtypes of offenders, some of which were consistent with the typology proposed by Mathews et al. The three categories proposed by Mathews et al are outlined below.

- Male coerced

  These women, briefly described above as a co-offender, tended to be passive females who often had histories of abuse and relationship difficulties themselves. These female sex offenders were more likely to be in an intimate relationship with their co-accused male and would, sometimes out of fear of abandonment, feel pressured into offending.

- Predisposed

  Mathews et al described this category of sex offenders as women with histories of abuse. They have psychological difficulties and deviant sexual fantasies and carry out abuse against their own children or children within their families.

- Teacher/lover

  These women, who often do not consider their acts as criminal, perceive themselves as in a romantic relationship with their victim. These women, at the time of their offence, were often struggling with peer relationships.

Research investigating adolescent female sex offenders is even more limited.

The US Centre for Sex Offender Management (2007) summarised the research available and outlined some common characteristics among juvenile female offenders including a high prevalence of sexual victimisation, having instability and dysfunction within the family home and as having co-occurring mental health difficulties. Adolescent female offenders are more likely to target young children within the family home or with whom they are familiar, target victims of either gender and often act alone, more often within the context of care-providing activities such as babysitting.

With regards to assessment, there are no empirically validated assessment tools for use on females. The US Centre for Sex Offender Management recommend exploring psycho-social and criminogenic needs, as these are often associated with general recidivism and are common treatment areas for adult offenders. Treatment aims to obtain the following, in addition to the traditional sex offender treatments outlined in the previous section: establishing and maintaining intimate relationships, promoting self-sufficiency, developing a positive self concept, enhancing assertiveness and social competency, developing more adaptive ways to manage emotions, reduce self-destructive behaviours, ensuring a healthy sexual development, expression and boundaries and addressing any other relevant mental health issues. Due to small numbers, research estimating recidivism amongst female sex offenders is difficult. Cortoni and Hanson, (2005) estimated general recidivism rates (including violent, sexual and nonsexual offences), based on their review of the literature, to be 20% over five years in adult female sexual offenders. The rate of sexual recidivism among adult female sex offenders was estimated to be approximately 1% by Bader et al (2010).

[63.620] Clergy and professionals

Possibly no other professional body receives as much attention as the clergy when it comes to the sexual abuse of children. There is no doubt that public opinion has demanded a proactive approach to preventing further sexual offences carried out by the clergy (Glancy and Saini, 2009). Generally, most of the research conducted has been of those of the Roman Catholic denomination.

Research attempting to determine prevalence rates of sexual abuse within the clergy have indicated that, based on estimates of 53,000 Roman Catholic Brothers and Priests in the United States, between 0.2% and 4% have committed sexual abuse against children (McGlone, 2003). In a review, Glancy and Saini, (2009) have found three general factors, which have been outlined below, that perhaps contribute to the incidence of sexual abuse carried out towards children by the clergy.

- Intrapersonal factors

  Langevin et al (2000) compared clerics who committed sexual offences against children with sex-offender controls that were matched by offence type, age, education and marital status and a control sample of 2,125 sex offenders matched by offence type only. They concluded that the clergy, in comparison to the other sex offending groups were older, more educated and predominantly single. They also reported that the clergy suffered from sexual disorders as well, particularly homosexual paedophilia. Separate from the other groups of sexual offenders, the clergy were also observed to have other medical problems, including diabetes and thyroid concerns. When examining personality characteristics measured by the psychometric measures common among the clergy engaged in treatment programs, Camargo, (1997) found higher levels of dependency and schizoid features in paedophile priests in comparison to a control group of non-offending priests.

- Interpersonal factors

  Fones et al (1999) explored the experiences of members of the clergy who had committed child sex offences and highlighted a number of intrapersonal struggles, including a desire to be known to others beyond their role, having few friends their own age, loneliness, having relationships with adolescents and having a lack of boundaries within their relationships. Markham and Mikail, (2004) found that the majority of their clergy child sex offenders also reported a high degree of loneliness, a lack of rewarding close adult relationships and an over-identification with the clerical role.

- Systematic factors

  Systemic factors included a lack of transparency and proactivity in the church response to allegations, a lack of training in the area of sexuality, a lack of clear ethical codes, a lack of supervision and a vow of celibacy (in some denominations) (Glancy and Saini, 2009)). Doyle, (2003) argued that "clericalism" may also contribute to sexual offending, defining this idea as a policy of maintaining or increasing the power of the church by creating a power imbalance between individual clerics and their parishioners.

Doyle, (2003) highlights a number of characteristics common in sexual abuse carried out by clergy: victims tend to typically come from families closely involved in the church; the abuse was more likely to take place multiple times over an extended period of time; when the abuse is disclosed, allegations were initially met with disbelief by parents and other members of the community; disclosures were not often made until the victim reached adulthood and many of the victims also were observed to suffer trauma and mental health issues following the abuse.

With regards to treatment, most argue that the treatment plan for a clergy sex offender would look similar to that for other child sex offenders (Glancy and Saini, 2009). Songy, (2003) also argues that the treatment models utilised with the clergy should reflect the needs of the offenders and, as such, some focus should be given to their role as clergy and the loss of these

roles. Songy also suggests that treatment programs also work towards reclaiming/maintaining their pastoral sensitivity and reconnection with their spiritual non-offending self-concept.

[63.660] Adolescents

While the age and behaviour of adult offenders make it easier to determine whether or not a child sexual offence has taken place, problematic sexualised behaviours are more difficult to define when both the victim and the perpetrators are children/juveniles, particularly if victim and perpetrator are close in chronological age. Araji, (2004) suggests that the first thing that should be considered when answering this question is whether or not the behaviour falls within normative standards on the basis of typical sexual development. However, definitions of this can vary across organisations, individuals and communities, and other individual aspects of development (eg, cognitive) should be held in mind. Ryan, (2010) also suggests that we consider the nature of the interaction between the youths and whether or not there was exploitation, consent and equality in the relationship. Conducting risk assessments on juveniles who sexually offend against other young people is difficult and requires a different approach to the one taken with adult child sex offenders.

Dicataldo, (2009) argues that juvenile sex offenders are a much more heterogeneous group than their adult counterparts and if there is any overlap between the two groups, then the future adult sex offender should be considered as "occupying a small static circle within the teeming and fluctuating, amorphous mass known as juvenile sex offenders" (p 26). Dicataldo argues that juvenile sex offenders are harder to distinguish from juvenile non-sex offenders than they are from the adult sex offender groups. As such, aetiological theories of adult sexual offending are not considered applicable to juvenile sex offenders. Although there have been several etiological theories developed that attempt to explain why some children and teens sexually abuse children, there is no simple formula. One of the most common theories, Social Learning theory, proposes that sexually abusive behaviour in children is underpinned by factors such as early exposure to sex, violence, negative childhood experiences (sexual abuse etc) and exposure to pornography and anti-social and/or violent family members. Other theories have highlighted the importance of cognitions (Hudson and Ward, 2000), separation-individuation processes in childhood (Chorn and Parekh, 1997) and family violence (Caputo et al, 1999).

Research has primarily focussed on the psychological and behavioural aspects of the offences when describing adolescent offenders (Freeman et al, 2005). However, most research concludes that juvenile sex offenders differ on a wide range of aspects, including types of offending behaviours, history of maltreatment, interpersonal skills and characteristics, familial characteristics, relationships, sexual awareness and experience, cognitive and academic functioning and mental health issues (Leversee, 2010). More recent research, though, has attempted to describe particular subgroups of the juvenile sex offending population. For example, Hunter et al (2003) compared adolescent males who offended against prepubescent children with those who targeted pubescent and post-pubescent females. They found that the former group had greater deficits in their psychosocial functioning, tended to use less aggression when carrying out the offence and were more likely to offend against relatives. Leversee, (2010) summarises the typology research and identifies four different types of juvenile offenders: those with psychosocial deficits; those with general delinquency and conduct problems; those with paedophilic interests; and those with co-occurring mental health diagnoses. Each of these is briefly described below.

- Psychosocial deficits

  These youths are described as having impaired social and interpersonal skills and often engage in sexually abusive behaviour towards others for sexual gratification and

socialisation. They may also carry out their sexually abusive behaviours as experimentation or as a way to compensate for skills deficits that have prevented the development of healthier peer relationships and to meet their intimacy needs. They are considered more likely to target younger children.

- General delinquency and conduct problems

  This group has greater levels of delinquency and may offend sexually against others as an extension of their general anti-social attitudes and behaviours. These offenders are more likely to offend against peers and adults, and tend to demonstrate greater violence and aggression during the offence. Etiological factors associated with this subgroup include physical violence by a male parental figure, modelled anti-social behaviours and male relative substance abuse. They may also be more likely to have dismissive attachment styles and may be indifferent towards the needs and rights of others. They are often considered to be at greater risk of committing a non-sexual offence than a sexual one.

- Paedophilic interests

  There is a small group of juvenile sex offenders who show deviant sexual arousal patterns to children. While the adolescent sexual arousal patterns are considered more fluid than adult sex offenders, it is considered that these youths are driven to offend primarily by an interest in children and may show early signs of paedophilia. Those with more fixated deviant sexual arousal patterns are more likely to target younger males as victims. In interviewing adult participants with self-identified attraction to children, Houtepen, Sijtsema and Bogaerts, (2016) reported that many of them struggled to acknowledge their paedophilic interest in early puberty and committed sex offences during adolescence when they were still discovering their feelings. This would suggest that early recognition of risk factors and the subsequent commencement of offence-specific interventions seem vital in preventing further child sexual offending.

- Co-occurring mental health disorder

  Adolescent sex offenders falling into this category tend to have other mental health issues such as anxiety, depression and substance abuse. It has been proposed that these types of young offenders may have their aggressive and sexualised behaviour impulses affected in some way by their mental health condition, which may lower the inhibitions against offending. Those with co-occurring mental health disorders and child sex offences may have developed the mental health conditions as a result of dysfunctional families and may have experienced a high level of abuse and neglect.

Recidivism rates for juvenile sex offenders are low, regardless of whether or not the offender completed a treatment program (Reitzel and Carbonell, 2006). When examining the follow-up data from over 1,000 juvenile sex offenders who participated in offence-specific follow-up over eight longitudinal studies, Alexander, (1999) found that the combined recidivism rates in a three- to five-year follow up were 7.1%. More recently, Reitzel and Carbonell, (2006) conducted a meta-analysis and found that the sexual recidivism rates were 12.5% among offenders in their sample. Of those convicted of a sexual offence, 24.73% went on to commit an additional violent offence, 28.51% committed non-sexual and non-violent offences and 20.40% committed an unspecified nonsexual offence.

Worling and Langstrom, (2006) provide an overview of the empirically supported (by at least two independent studies) factors associated with greater risks of recidivism. These include

deviant sexual interests, prior criminal sanctions for sexual offending, sexual offending against more than one victim, sexual offending against a stranger victim, social isolation and uncompleted offence-specific treatment. They also acknowledge the "promising" risk factors that show some evidence of empirical support. These include problematic parent-adolescent relationships and attitudes supporting of sexual offending. The following factors are also considered to be linked with greater re-offending rates, but lack a strong empirical base: high stress family environment, impulsivity, antisocial interpersonal orientation, interpersonal aggression, negative peer associations, pre-occupation with sex/sexual themes, sexual offending against a male victim, sexual offending against a child, using threats, weapons or violence during the sexual offence and being in an environment that is supportive of re-offending. Finally, they highlight factors that are *unlikely* to be associated with greater risks of re-offending (based on current studies), including the offender's own history of sexual victimisation, history of non-sexual offending, sexual offending involving penetration and low victim empathy.

With regards to assessment, there is not enough research currently to validate "pure" actuarial tools in adolescents. The current practice is to identify the relevant empirically validated risk factors which are then used to guide intervention plans. This is most consistent with the structured professional judgement approach to risk assessment described previously.

Currently, there are two main assessment tools used to assess risk in juvenile sexual offending that show early empirical support: the Juvenile Sex Offender Protocol (J-SOAP -II; Prentky and Righthand, 2001; 2003) and the Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR; Worling and Curween, 2001). Both tools were designed to be used on those aged between 12 years and 18 years and provide scoring guidelines on each of the items and identify relevant risk factors to guide intervention plans and management strategies.

Clinicians have historically used adult treatment programs with juveniles. However, the evidence suggests that the juvenile sex offender is vastly different from the adult child sexual offender and, therefore, the adult programs are unlikely to be as efficacious. Developmental, social and interpersonal deficits that many of these young offenders present with must be given consideration when developing an intervention plan. Programs holistic in nature are considered more likely to be efficacious (Print and O'Callaghan, 2004). Worling, (2004) outlines areas that should be considered in interventions (including social skills; human sexuality education and romantic relationships; anger expression and control; impulse control; and prior victimisation and/or trauma) in addition to offence-specific factors. Offence-specific aspects include reducing deviant sexual thoughts; self management of risk strategies; influences on arousal patterns; consequences of offending; and victim awareness (Print and O'Callaghan, 2004). Some more recent approaches, such as Ayland and West's "Good Way" model (2006), have looked at integrating a narrative of the individual's life and offending and changing this life story in a more positive way. Such approaches seem likely to shape treatment programs into the future.

[63.700] The elderly

There is relatively little written about older child sex offenders and obtaining prevalence data on the older child sex offender is difficult. There has been some research to suggest, at least in the United States, that child sexual crimes perpetrated by older offenders (usually defined as those over the age of 60 years) is increasing (Clark and Mezey, 1997). The relationship between age and general rates of offending indicates that juveniles commit the largest number of crimes and that the frequency of offending reduces over time. Trends regarding sexual assaults, however, tend not to conform with these general patterns of behaviour. The largest peak appears to be at the age of 13 years and a second peak in the mid to late 30s (Fazel et al, 2006). One hypothesis explaining this bimodal age distribution for sex offenders generally

include arguments around the offenders having greater access to children as they age and as they become fathers, uncles, etc (Hanson, 2001). Further research has shown that sex offenders who target adult victims tend to be younger than those who target children (Hanson, 2001). As research shows a much lower number of older child sex offenders than younger offenders, does this mean that the older offenders pose a lower risk of committing further child sex crimes in the future?

In a review of 21 follow-up studies, Hanson and Brussiere, (1998) found an overall negative correlation between age and risk for sexual recidivism; however, the effect size was not large and there was variation between the studies included in the meta-analysis. Hanson, (2001) looked at recidivism data from a number of studies (examining approximately 4,000 offenders in total) and divided them into groups according to the victim's age and relationship to the offender (adult women, unrelated children and related children). Sexual recidivism for the total sample was calculated at 17.5%, and the rate of recidivism decreased with age. Older sex offenders represented a small percentage of the sample (11%), with recidivism rates considered to be lower than 10%. Interestingly, however, the rate of recidivism for extra-familiar child sex offenders remained relatively stable until they reached the age of 50 before decreasing.

In a descriptive study of child sex offenders over the age of 65, Clark and Mezey, (1997) argue that older sex offenders are similar to adult child sex offenders with regards to the seriousness of the sexualised behaviour, length of offending and number of victims, but had a tendency to come from higher socio-economic environments, had lower rates of victimisation themselves and had more stable backgrounds. They argued that the older sex offenders in their sample tended to receive more lenient sentencing and suggested that this may reflect the justice system taking into consideration their age and infirmity and/or assumptions that they are likely to pose a lower risk of recidivism in the future. A number of reasons explaining the low number of older offenders and lower rates of recidivism include lower testosterone levels (Barbaree et al, 2003), sexual functioning, sexual thoughts, sexual enjoyment (Rowland et al, 1993) and an increase in self control (Hanson, 2002) and mortality (Clark and Mezey, 1997).

Little has been written about the treatment of older sex offenders. Some authors such as Clark and Mezey, (1997) have questioned the usefulness of cognitive behavioural treatment programs (which generally aim to promote the offenders to accept responsibility for their offending, identify situations which increase their likelihood of offending and being able to manage these situations without returning to their offending behaviours), arguing that the offenders' motivation and capacity to alter perhaps more entrenched thinking/distortions may be low. Barbaree and Blanchard, (2008) highlight that although there is evidence to suggest that risk of recidivism reduces with age, there is some argument as to whether or not there needs to be an adjustment to the estimate of risk in the older sex offender. This argument, supported by others, has been based on questions around the validity of age-related studies highlighting decreases in recidivism (Harris and Rice, 2007). As such, treatment approaches and interventions for older offenders probably should mirror those for the younger offenders, taking into account individual risk factors and strengths. In 2002, Fazel, Hope, O'Donnell and Jacoby studied 203 sex and non-sex offenders over the age of 59 and examined the prevalence of psychiatric comorbidity and personality disorders between these two groups. Their results indicated that sex offending among the elderly may be more associated with personality factors rather than mental illness or organic brain disease (such as dementia).

[63.720] Child sex offenders with an intellectual impairment

Those with an intellectual impairment who commit child sexual offences not only present additional challenges within the judicial system (where questions may arise around whether or

not they understand their charges and can participate in the legal processes etc) but also add another dimension to their assessment, treatment and management approaches. While some research has found that those carrying out child sex offences score lower on tests of intelligence than other offending and non-offending populations (Cantor et al, 2005), this does not automatically mean that they have an intellectual impairment. Those considered to have a significant intellectual disability, according to the DSM-V, must not only have their intellectual capacity estimated to be at 70 or below, but they must also show considerable social and adaptive functioning impairments, and this is the group that is the focus of this section.

Estimating the prevalence of intellectually impaired sex offenders is often difficult, especially when using incarceration statistics as the gauge. In 2008, the Australian Institute of Health and Welfare reported that 588,700 (or approximately 3% of the total population) had an intellectual disability; however the proportion of sex offenders with an intellectual disability in prisons is considered much higher than this rate (Hayes, 2004). Some argue that using prison samples to estimate prevalence is somewhat flawed, as it may reflect increased arrest and conviction rates as opposed to prevalence per se (Griffiths et al, 2004). There are a number of methodological difficulties in trying to determine the number of child sex offenders with an intellectual impairment, such that Lindsay, (2002 argues that there is insufficient evidence to say whether or not intellectually disabled people are over or under-represented in the sex offender prison population.

With regards to the range of offences carried out by child sexual offenders with an intellectual impairment, they appear comparable to the non-disabled population. Griffiths and Fedoroff, (2009), in their summary of the research comparing the intellectually impaired and non-intellectually impaired sex offender, describe the intellectually impaired sex offenders as:

- more likely to be victims of sexual crimes,
- commit less serious offences but are more likely to engage in non-contact inappropriate sexualised behaviours such as public masturbation, exhibitionism and voyeurism,
- have fewer victims,
- have a larger proportion of male victims (although there is some disagreement in the literature about this),
- have greater social skill deficits, are more sexually naïve and lack interpersonal skills and
- have greater difficulty interacting with the opposite sex.

Craig and Lindsay, (2010) summarise a number of aetiological theories put forward to help explain the incidence of sexual offences amongst those with an intellectual impairment.

- Counterfeit deviance

  This theory argues that those with an intellectual impairment commit sexual offences, not as a result of sexual deviance but as a consequence of a range of cognitive and developmental difficulties, including a lack of sexual knowledge, poor social and interpersonal skills, limited opportunities to establish appropriate relationships with sexual partners and sexual naivety. Although recent research looking into the legitimacy of this theory has raised a number of concerns such as whether or not these deficits simply increase their risk of detection or whether or not this theory describes only a sub-section of offenders, current thinking maintains that this theory does make an important contribution to the understanding of sexual offending among those with an intellectual impairment.

- Deviant interests and lack of discrimination

  This theory suggests that intellectually impaired child sex offenders do so as a result of a developing or an entrenched deviant sexual interest which is mediated by cognitive distortions and attention to cues that are often misinterpreted as sexual in nature. This theory tends to be supported by some recidivism data that suggests that some of these offending behaviours continue to persist, and other research highlighting the role of preference in victim selection.

- Sexual abuse

  Similar to the sexual offenders without an intellectual impairment, it has been argued that the perpetration of sexual offences is associated with the offender's own sexual abuse. Again, this theory has arisen from data that indicate the incidence of sexual victimisation is over-represented in sex offenders with an intellectual impairment. As highlighted previously, however, this is not considered a complete understanding of sexual offending, as not all offenders have histories of sexual abuse.

- Personality characteristics and impulsivity

  This theory suggests that sexual offences among those with an intellectual impairment are underpinned by personality characteristics. Recidivism research shows the importance of personality aspects contributing to re-offending. Specific factors considered important include psychopathy, anti-sociality, impulsivity, immature social skills, low self-esteem/high self-criticism, poor empathy and deficits in being able to process and evaluate information. However, some research indicating that sex offenders demonstrated an awareness around the importance of grooming behaviours and gaining trust and a capacity to delay sexual gratification suggests that this is an incomplete aetiological theory.

- Mental illness

  This theory suggests that a co-occurring mental health disorder may act as a disinhibitor to the sexual offences carried out by those with an intellectual impairment. There seems to be little doubt that there is a high degree of co-morbidity among those with an intellectual impairment, but some research has argued that after a further investigation into the mental disorders diagnosed, many of these diagnoses have been made on the basis of behavioural difficulties alone. Although research attempting to explore the role of mental illness within sex offenders with an intellectual impairment needs to overcome a number of methodological challenges, the data to date suggest that a mental illness is not a primary motivator for sexual offending in most cases.

With regards to risk assessment, Lindsay and Taylor, (2010) report that the VRAG has demonstrated significant predictive validity among sex offenders with an intellectual impairment. Studies have also shown predictive accuracy for the VRAG, HCR-20 and the PCL-screening version. Lindsay et al (2004) have found that specific factors considered to be correlated with further offending among those with an intellectual impairment include antisocial attitudes, low self-esteem, lack of assertiveness, allowances made by staff, staff complacency, poor response to treatment, attitudes tolerant of sexual crimes and erratic attendance. Factors considered to be most predictive of further offending include, staff engaged with the offender's care allowing too much latitude because of the person's impairment, antisocial attitudes and a poor relationship with mother. However, while the standard tools appear to have sound predictive abilities, there are questions around whether or not these are

suitable to use with those with an intellectual impairment. In attempts to develop a more appropriate assessment tool for use with intellectually impaired offenders, Boer and his colleagues (2004) developed a clinically guided assessment tool, the Assessment of Risk Manageability for Individuals with Developmental and Intellectual Limitations who Offend (ARMIDILO). The ARMIDILO, used with an actuarial test and clinical guidelines, allows the assessor to not only assess risk but also provide a management framework at the same time (Craig et al, 2008).

With regards to treatment, there has been a marked decline in the institutionalisation of intellectually impaired offenders. This appears to have had a positive influence on these offenders completing treatment in community settings. Having access to community support and services generally appears to have resulted in a greater sense of community and lowered rates of recidivism (Lindsay et al, 2010). While there are a number of treatment programs available, the best programs are holistic and target a range of difficulties, not just the sexualised behaviour. Availability of such services varies significantly across jurisdictions.

[63.740] Internet-mediated offences

The internet has dramatically influenced the way in which we live. It has facilitated education, made communicating with others more accessible and eased the coordination of activities. However, not all applications have been used to advance society in a positive way. With a wider range of websites and improvements in technology, the internet has the potential to normalise sexual violence and deviant sexuality as well as provide users with new ways to offend sexually.

Unlike other paraphilias, there are not yet generally accepted diagnostic criteria that allow us to define problematic online sexual behaviour (Quayle, 2008), and trying to quantify the scale of the problem is difficult. We often have to rely on the effects or the legality of the behaviour to determine whether or not it is problematic. As well as viewing/downloading/creating/sharing illegal images (such as child exploitation material) on the internet, Quadara, (2010) also describes a range of inappropriate online sexual behaviours, including the solicitation or seduction of others online in an effort to meet them in person where a sexual offence may later take place, creating and disseminating sexually explicit photographs or videos and using social networking sites to intimidate and harass (perhaps sexually or in regards to a sexual matter). In addition, the legality of these behaviours varies across jurisdictions.

It is difficult to determine the age at which internet offending can begin, given that the majority of the population has access and the skills to utilise the internet (Quayle, 2008). Similarly, the true community prevalence and incidence of offending are impossible to gauge considering the resources needed and the complexities around detecting and sentencing offenders. Sample studies are usually of those who have been detected or charged and thus may fail to investigate the greater population. Studying a sample of 685 male patients referred for an assessment of their sexual interests and behaviour, Seto, Cantor and Blanchard, (2006) divided their sample into those convicted of child pornography offences, those who had not been charged with pornography depicting children offences but charged with contact offences against children, those who committed sex offences against adults and those referred for a general non-offending sexology assessment. Using phallometric testing to measure arousal while presenting participants with slides accompanied by audio-taped narratives through headphones, these authors found that child pornography offenders were almost three times more likely to have met the criteria for paedophilia than the other groups. This group was also less likely to respond to stimuli depicting adults than the other two groups. Seto et al (2006) importantly propose that child pornography offending is a valid diagnostic indicator of paedophilia and that it is much more reliable than sexual contact with child victims.

With regard to the demographic characteristics in a USA sample in 2003, Wolak, Mitchell and Finkelhor reported that an estimated 2, 577 arrests were made in the 2000-2001 financial year period in the United States for internet sex crimes committed against minors. They reported that the majority (approximately two thirds) of these offenders possessed child pornography, with 83% of the images being of children between the ages of 6 years and 12 years old and 80% showing sexual penetration of a minor. The offenders in the study were predominately non-Hispanic, white males over the age of 25 years. Wolak, Finkelhor and Mitchell, (2005) further studied this group and reported that offenders were likely to have a high school education, 62% were unmarried, although 42% had biological children, and 34% were living with children at the time of the crime. Almost half (45%) were in a residential, social or employment situation that allowed them access to children. A smaller number (18%) had substance abuse issues, mental health diagnoses (5%) and sexual disorders (3%).

The research seems to agree that there are different types of offenders utilising the internet to commit crimes involving children. While Wolak, Mitchell and Finkelhor, (2003) divided internet sex crimes against minors into three mutually exclusive categories (those that involved internet-related sexual assaults and other sex crimes such as the production of child pornography committed against identified victims; internet solicitations; and the possession, distribution or trading of internet child pornography by offenders who did not use the internet to sexually exploit identified victims or solicit undercover investigators), Babchishin, Hanson and Hermann, (2011) argue that there are four somewhat similar groups (those who do not have a sexual interest in children, but who access the internet out of curiosity or impulse; those who access pornography to satisfy sexual fantasies; those who create and distribute child pornography; and those who use the internet to procure potential victims to commit contact offences). Given the consistency in the research indicating distinct groups of offenders utilising the internet, these groups have been discussed individually below.

Accidental or curious viewers

One could legitimately hypothesise that prior to the advent of the internet, the majority of individuals viewing pornographic material as a result of curiosity or chance would not pro-actively move from accidental/curious viewer to seeking out further pornographic material to view on a regular basis (Quayle & Taylor, 2002). The shift from accidental/curious viewer to regular viewer has historically involved the viewer being motivated and able to overcome possible obstacles to accessing material. Thus, 30 years ago a young adolescent having been shown a pornographic magazine by a peer (a relatively normative developmental experience) would need to invest time, effort, energy and thought into how to obtain further pornographic material. The human condition dictates that individuals will focus on non-primary drives only when conditions are sufficient such that the amount of energy expended to achieve the aim is lesser or equable with the perceived reward that will be achieved.

Quayle and Taylor, (2002) argue that the internet may play an important role in making child pornography more easily available and that this in an addition to the fact that potentially this could be done in more private settings could, in turn, potentially reinforce deviant sexual arousal patterns through masturbation which may then lead to the development of paedophilia or the engagement in further offences. In their exploratory study of 13 offenders convicted of charges relating to child pornography, they report that their sample not only had little difficulty finding child pornography but they were able to find material that met their sexual proclivities. However, despite an increase in the availability of child porn material, and the argument that greater exposure may result in a greater number of sexualised problems and potential victims, rates of reported child sexual abuse in the US have steadily decreased since the mid-1990s (Wolak et al, 2010). So while research is yet to show a causal link between online viewing and later contact offences, more research is needed to explore other possible effects of ongoing and

prolonged exposure to internet child pornography given the internet's utility and the exposure one has to other offenders and greater access to material. For example, Allen et al (1995) found that exposure to nudity diminished aggression, but that non-violent and violent pornography increased aggressive behaviour. Similarly, Allen et al (1995) also found that an association existed between exposure to sexually arousing material and rape myth acceptance (holding cognitive distortions and attitudes associated with being able to commit sexual assault). Presumably though, not all those accidentally or accessing child pornography out of a curiosity will develop an interest in it, develop a sexual attraction towards children or seek to commit hands-on offences against children (Reijnen et al, 2009), emphasising the need for greater research into the area to determine what interpersonal and contextual factors make someone more likely to develop problems with ongoing exposure.

Internet child pornography offenders

Internet child pornography offenders are defined by their engagement in the collecting/downloading and/or circulating child pornography over the internet. In Australia, the specific Acts and legislation relating to child pornography differ from state to state. However, the definitions are similar and generally describe child pornography as indecent or offensive material in which a child (someone who is, or appears to be, under 16 years of age in Queensland, New South Wales, South Australia and Western Australia, and 18 years of age in Commonwealth, Tasmania, Victoria, the Northern Territory and the ACT) is depicted or described in a sexual, offensive or demeaning way, or being shown to be subjected to abuse, cruelty or torture. Being convicted of possessing child pornography can lead up to 10 years imprisonment and/or a $120, 000 fine.

Burke et al (2001) reported that on the basis of their clinical experiences, those who utilise child pornography were generally aged 25-50 years old without prior convictions for criminal offences. Using empirical data, however, Galbreath et al (2002) found that, in a group of 39 offenders, only 64% were without an official criminal history. Burke et al (2001) further describe the typical offender as being better educated, having a higher intelligence, being more likely to be employed and in a relationship than child sex offenders charged with contact offences. Webb et al (2007) found that compared to child molesters, the internet offenders were more likely to report psychological difficulties in adulthood and also fewer prior sexual convictions.

With regards to offending histories and recidivism, Seto, Hanson and Babchishin (2011) conducted two meta-analyses and found that approximately 1 in 8 (12%) of the online offending participants had an official criminal history, including contact sexual offences and approximately 1 in 2 (55%) disclosed engaging in a contact sexual offence when asked to self-report. In a one-and-a-half– to 6-year follow up, they reported that 4.6% of online sex offenders committed a new contact sexual offence, and 3.4% had been found to re-commit a new child pornography offence.

While early research indicates that recidivism for this group of offenders is low (Webb et al, 2007), questions are often raised about whether internet child sex offenders eventually "graduate" to committing crimes against children that involve actual contact (Malesky et al, 2009). In an attempt to answer this question, Seto and Eke (2005) obtained recidivism data for 201 child pornography offenders. Of their sample, 56% had previous criminal offences (including sexual and non-sexual offences). With regards to recidivism, 17% offended again during the follow-up period of 29.7 months at risk. Of the offenders who committed child pornography offences, only 1% went on to obtain a criminal charge for a contact offence, although 4% committed an additional child pornography offence. Endrass et al (2009) also found a low recidivism rate with 0.8% of child pornography offenders going on to commit a

contact offence after a six-year follow-up. Supporting this low recidivism rate, Riegal (2004) conducted an anonymous online survey for self-identified "Boy-attracted Pedosexual Males" and found that 83% of respondents used child pornography as a substitute for actual contact offences, with 84.5% indicating that viewing the material did not increase their desire to commit a contact offence.

Those who create and upload child pornographic images

While there has been some research into the types of people accessing child pornography images, little is known about those who provide images on the internet. Presumably, there would be a number of different groups contributing to the materials available online. These would include those uploading images to make money from the selling of these materials (Schuijer and Rossen, 1992), those who upload images following the abuse they perpetrated as a result of their own offending behaviour, as well as those who share images they have collected with others, who may or may not have produced the images themselves but who collect the images out of a sexual attraction to children. It is also likely that the decision by some to upload and distribute images could be driven by more than one of these motives. It is also possible that with the advances in technology, images not necessarily involving children can be manipulated so that it looks like child pornography. More information about these offenders is likely to have an impact on detection and prevention strategies and could potentially reduce the availability of online child pornography images.

With regards to the victims utilised in the images, Quayle and Jones (2011) randomly selected 10% of the 247, 950 images seized by the police and stored by the Child Exploitation and Online Protection Centre in the UK. They found that the odds of the images being female versus male were around 4 to 1. The majority of the children in the images were white, with a ratio to non-white children being just under 10 to 1. Similarly, Baarz (2008) studied 50 consecutive Australian cases and found that the images were mostly of white, westernised, female children between the ages of 8 years and 12 years.

Those using the internet to procure victims to commit contact offences

This group of offenders is described as using the internet to exploit and/or lure a child to engage in an offline (or online) sexual offence, usually after a period in which they have built trust and introduced sexual content (Medaris and Girouard, 2002). Briggs et al (2011) conducted an exploratory study using 51 offenders convicted of an internet-based sex offence in which they attempt to lure an adolescent into a sexual relationship using an internet chat room. They found that the ages of the victims ranged between 12 years and 16 years which is consistent with other findings (such as Walsh and Wolak, 2005), suggesting that this group of offenders select victims on the basis of visual maturity and are less likely to be paedophiles. Briggs et al (2011) also argued that these offenders are driven to offend by less criminogenic factors and are therefore at lower risk of recidivism than other offenders such as rapists and child molesters. They hypothesised that they engaged adolescents in online chat rooms as a means of avoiding relationships and utilise the internet as a primary social and sexual outlet.

Interestingly, in a study surveying law enforcement officers about internet-related sex crimes against juveniles, Wolak et al (2010) found that most offenders were charged with crimes such as statutory rape that involved non-forcible sexual activity with those too young to give legal consent. They reported in their study that offenders utilising the internet to procure victims rarely used deception. Of their sample, only 5% of offenders pretended that they were teens when using the internet to communicate to their victim. The study indicated that most offenders discussed sex (including their interests) online and as such, many of the victims who met their offenders face-to-face were expecting to participate in sexual activity. If there was

deception, these authors argued, it was mostly in relation to promises of love and romance by the offenders when their intentions were purely sexual.

More research is required to determine what factors are important with regard to predicting recidivism. Most of the research used to validate sexual risk assessment tools did not consider the internet offender and as such normative samples and the predictive utility of variables related to these offender's recidivism were not explored (Malesky et al, 2009). So it is unknown as to whether or not the same predictive variables apply (Middleton et al, 2006) or even whether all internet child sex offenders are similar enough to be categorised into one single group. It is likely that the relatively low rates of recidivism also contribute to the difficulty in developing a tool that can determine and differentiate risk. Although work has begun in developing and identifying tools to assist in risk assessments, such as the Risk Matrix 2000 scales and Offender Group Reconviction Scale 3 (Wakeling et al, 2011), much more research is needed.

Given the potential heterogeneity of the population and the lack of tools, Malesky et al (2009) suggest identifying the offender's dispositional factors that led to the offence to begin with and focus on these in a treatment setting as a means to reduce risk. Ward and Beech (2004), based on the work of Hanson and Harris (2001) and Thornton (2002), developed an etiological model of risk which incorporated the following dynamic risk factors: sexual self-regulation (sexual preoccupation, deviant sexual arousal, using sex for coping and emotional regulation etc); general self-regulation problems (planning, problem solving and regulating impulses); intimacy deficits (choosing inappropriate partners as a result of failing to establish a relationship with an appropriate partner, emotional loneliness etc); and offence supportive cognitions (beliefs that justify and disinhibit sexually abusive behaviours). Malesky et al (2009) argue that assessing these, as well as exploring the offenders' association with people who have anti-social values and criminal tendencies, may be a start in identifying key indicators of future risk for child sex offenders who are downloading images of child sexual abuse from the internet. There is little research about psychological interventions for these offenders; however, there are early indications that treatment can improve socio-affective functioning and decrease pro-offending cognitions which may play a key role in this (and other types of) offending behaviour (Middleton et al, 2009).

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QUALIFICATIONS OF EXPERTS

[63.900] Overview

In the opinion of the authors, the knowledge, skills and attitudes of an expert with regard to this population are more important than their formal qualifications. That said, individuals working in the field require training and appropriate membership or registration of a professional mental health discipline. Some professions will have discipline-specific abilities (eg, prescribing medicines, assessing cognitive function and administering certain standardised measures). All professionals should have an understanding of the current scientific literature relevant to this specific field and how this would apply to the individuals they are dealing with. Practitioners should be transparent regarding their level of experience with regard to this population in treatment or assessment. Ideally, initial experience in assessment or treatment should be obtained in the context of professional supervision from a practitioner with a high level of experience dealing with this population. Professionals should be aware of dual or multiple roles and responsibilities and deal with these effectively either by minimising them or through the use of appropriate transparency and planning. For example, professionals providing group treatment programs in corrective services settings have responsibility not only to the offenders they are treating but also to their employing authority and the protection of the wider community. Clear policies, protocols or professional practices are helpful in dealing with these potential "conflicts of interest". Practitioners should be aware of relevant professional codes and guidelines regarding treatment or provision of independent medico-legal assessments and adhere to these.

Practitioners providing independent assessments for courts should follow good practice guidelines with regard to such reports (which are not specific to the issue of child sex offenders). For example, they should be focused on the responsibility to assist the court in its decision-making processes rather than becoming advocates for one party or the other and they should be transparent about the report process and the data utilised to come to opinions. Professionals should only use instruments (structured rating scales and similar tools as described previously in the risk assessment section) if they are aware of the reliability and validity of such instruments and any limitations of the applicability of the instrument. Appropriate training should be undertaken (depending on the instrument) and standardised manuals used when scoring instruments regardless of the experience level of the practitioner.

Peer review processes, formal training courses or professional supervision can be extremely helpful in maintaining and improving expertise in this (or any professional) area and maybe more essential given the nature of the sexual and violent material that practitioners are exposed to.

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SPECIAL LEGAL CONTEXTS

[63.1000] Overview

There are a number of legal situations which present specific scenarios for professionals and we will briefly comment on these.

Family court

In the Family Court of Australia, allegations of child sexual abuse are frequently raised. Additional complexity occurs in the investigation of child sexual abuse, particularly in children of an age where it is difficult for them to give a coherent narrative of the events (under five years of age, for example). There may be no corroborating evidence from forensic medical data, interviews or witnesses but the child may still have been sexually abused. This sometimes does not become known until years later. The least complicated situation occurs when there is an investigative process and an individual (usually one of the parents) is charged and then convicted of child sexual offences against one of the subject children. Professional experience is that these cases often hinge on confession by the perpetrators. Expert opinion can be sought with regard to recidivism risk in child protection matters, although in our experience this is unusual.

Another situation is where there are allegations of child sexual abuse, there is an investigative process where the standard of proof required for a child protection matter is reached but the evidence is not strong enough to proceed to criminal charges, or criminal prosecution is undertaken but is unsuccessful. In such matters, expert opinion can be of some use, particularly from a child protection point of view when seeking to ensure that the child is protected physically and psychologically.

Unfortunately, a more common scenario is for there to be allegations made but no substantiated outcome from an investigative process. This situation can be divided into a number of groups.

The first is where the child protection investigators are suspicious that there was some untoward event but no substantiating data can be obtained at interview or by corroboration from other sources.

The second is where no substantiating data is found, there is no suspicion on the part of investigators that an event has occurred and the parties are able to move on from this.

The third is where no substantiating data is found, there was no suspicion on the part of investigators that the event had occurred but one or the other party persists with the allegations and becomes fixed in their view that abuse has occurred regardless of the lack of data to support this. In this last situation, professionals are often involved in evaluating the family and parents to understand why a parent or a caregiver is adhering to their views in the face of no data supporting the position.

There are a number of explanations for this behaviour. The most common appears to be a very vigilant anxious parent or caregiver who has an acrimonious relationship with the other party and are suspicious of the actions and/or motivations of the other party, thereby leading to

misinterpretations of actions and statements and situations and becoming fixed in their view that the other party is sexually harming the child.

A second explanation occurs when the party who is fixed or preoccupied has a psychotic illness and the beliefs are delusional in nature.

A third explanation is that the parent is manufacturing their view for advantage in the legal matter. This becomes in itself a child protection matter, as children are harmed by this sort of behaviour in a parent.

Civil damages

Qualification of civil damage when an individual has been sexually abused as a child is a complex matter. The nature of the abuse alone does not dictate the level of dysfunction that may occur. What may appear to be relatively inconsequential in nature to a lay observer might turn out to have significant psychological implications in the long term.

It is important to have independent assessment by an expert soon after the child abuse is dealt with legally so that later assessment has a clear recording of psychological function and symptoms as close as possible to the time of the injury. It is equally prudent not to finalise the evaluation of the effect of sexual abuse on young people until they have successfully matured into adulthood, given the issues around psychosexual development that occur during adolescence.

This also allows for more certainty with regard to the effect of the injury on the person's potential work, study or earning potential.

Continuing detention legislation

Legislation allowing for the ongoing supervision or detention of sexual offenders is present in a number of jurisdictions worldwide and most Australian legal jurisdictions. There has been extensive debate in legal and mental health circles regarding this legislation. It is not our intention to canvass this debate.

This has, however, led to polarised statements about professionals' involvement. Some professionals have suggested that it is unethical for practitioners to be involved in assessments or similar for such legislation. The basis for this statement is often unclear and in our opinion individual professionals must decide for themselves whether involvement falls within professional and personal ethical boundaries for them.

If professionals are to be involved in such practice it is their responsibility to practice within their area of expertise and to provide the highest possible level of professional advice to assist the courts in making very difficult determinations under these legislative acts.

[The next text page is 63-801]

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