Submission No 5

SENTENCING OF CHILD SEXUAL ASSAULT OFFENDERS

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A submission by the Australian Psychological Society to the Joint Select Committee on

Sentencing of Child Sexual Assault Offenders

This submission was prepared by the NSW Section of the APS College of Forensic Psychologists

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Preamble

The Australian Psychological Society (APS) thanks the Joint Select Committee on Sentencing of Child Sexual Assault Offenders for the opportunity to provide a submission. This submission considers the impacts of sexual assault on children, and concerns itself with the issues surrounding the sentencing and rehabilitation of sex offenders.

The contributors to this submission are available should the Committee wish to hear individually from any or all of the authors.

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About the APS

The APS is the peak body for psychologists, representing over 21,000 members. The APS has nine Colleges that represent specific areas in psychology. Each College promotes its area, maintains practice standards and quality assurance, and encourages and supports the education and professional development of practitioners. The College of Forensic Psychologists is one of these.

Forensic psychologists are scientist-practitioners. They apply psychological knowledge, theory and skills to the understanding and functioning of legal and criminal justice systems, and to conducting research in relevant areas. They often work in criminal, civil and family legal contexts and provide services for litigants, perpetrators, victims, and personnel of government and community organisations.

Executive Summary

Child sexual assault offenders are a heterogeneous group, however the majority of offenders are of low risk. The impacts of child sexual assault are varied, with many victims/survivors showing elevated risk for physical and mental health concerns, and/or future involvement in the justice system. Leadership is required to provide a better level of understanding of both the effects of, and the risk of child sexual assault offending. Sentencing of sex offenders needs to take into account the risk level of offenders to guide the judicial response. Treatment is a useful adjunct for the management of offenders and a 'through care' model involving the coordination of in-gaol and in-the-community care of offenders needs to occur. There should be good communication between supervision, management and treatment of offenders and the most parsimonious model for delivering appropriate interventions to sex offenders in the community will be a mix of diversionary, private and public funded services.

Recommendations

The submission makes the following recommendations to the Committee.

1. Sentencing principles should be as based on judicial discretion within a legislated range for appropriate convictions but without stipulating mandatory sentencing periods.
2. Risk assessment undertaken by suitably qualified and accredited professionals should be contributory to a determination of severity and type of sentence to be provided to an adjudicated sex offender.
3. There is a need for a 'through care model' between custody and community, and communication between agencies and practitioners charged with the responsibility for detention, supervision and treatment of adjudicated sex offenders.
4. The 'through care model' needs to take into consideration sentencing considerations and judicial remarks, as well as best practice guidelines for treatment.
5. As the treatment and assessment of sex offenders is a technically demanding area, a Child Sex Offender Counsellor Accreditation Scheme (CSOCAS)-like accreditation system needs to be maintained and applied to all professionals working as specialists in the sex-offending area.
6. Given the general difficulties in obtaining convictions, there is a need to consider incentives or alternative models of justice such as diversionary programs in order to provide helpful outcomes for victims and minimise the trauma (particularly for children) of having to go through a court process.
7. A careful consideration of community management systems needs to occur; in particular caution in the use of the Child Protection Register (CPR) for low risk and young offenders should occur. Where an order for CPR is made, it should be based on the risk assessment undertaken and judicial comments on sentencing.
8. Given that the most sex-offenders are low risk and unlikely to receive custodial sentences, or will receive sentences precluding engagement in gaol-based treatment, there is a need to considerably bolster treatment resources in the community, preferably through a public/private partnership approach.
9. Sentencing and treatment approaches need to be matched by a public information program demystifying sex offending and creating a climate conducive to the rehabilitation of offenders.

Introduction

Child sexual abuse (CSA) rates vary according to which survey, and the methodology and definition of CSA, used. Surveys in non-clinical populations have been conducted in at least 20 countries suggesting base rates for the victimisation of females range from 7% to 36% and for males range from 3% to 29%. Typically the profession accepts that a figure of about 30% of girls will be sexually abused and about half that number for males, with 'serious abuse' (that is penetrative sexual abuse) being experienced by about 10% to 17% of girls (Cashmore & Shackel, 2013; Finkelhor, 1994; Ogloff, Cutajar, Mann, & Mullen, 2012).

Victims and survivors

There remains debate, often contentious, about the impacts of child sexual abuse. Terms of the debate include:

- The percentage of children who may or may not develop mental health or trauma symptoms
- The notion of delayed impacts (for instance, some children may not reveal symptoms but then, on having their own children, suddenly develop trauma related symptoms as a result of their own abuse in childhood)
- The type of symptoms a child may experience
- Causality of CSA for later development of symptoms (for instance there is a risk that any deviation from normal behaviour may be viewed as a result of earlier victimisation instead of more proximal causes of behaviour)
- Whether there are 'typical' symptoms of child abuse (Browne & Finkelhor, 1986; Hamby & Finkelhor, 2000) (usually the answer to that is there are no typical symptoms although anxiety based symptoms are frequently observed)
- Whether children lie about their victimisation (Fergusson, Horwood, & Woodward, 2000).

CSA events mostly occur within the context of family, and primarily during interactions between children and trusted family members or other trusted adults (Smallbone & Wortley, 2001). In addition there is a gathering consensus in the research field that up to half or even more children who experience sexual abuse will do so at the hands of other (older) children (often siblings or cousins) although it is sometimes the case that the alleged victim, usually a girl, is the older child. Most professionals and most studies agree that the original claims of a child as to being sexually abused are believable and likely real.

The impacts of CSA are varied. Browne and Finkelhor (1988; see also Hamby & Finkelhor, 2000) claimed the most common symptom of CSA was, in fact, no symptom, although they also acknowledged that only a minority of abused children showed no symptoms. There was no consistency however among the varied symptoms revealed by the majority of victims. Finkelhor and colleagues have shown through various surveys that between 25% to as much as 40% of children may not experience any direct symptomatology as a result of CSA. This research has been criticised for its failure to consider long term delayed impacts, and retrospective reporting. Ogloff and colleagues (2012) found that more than half of a sample claiming to be victims of CSA had subsequent police involvement with almost a quarter (23%) having a criminal history compared to only 5.9% of matched, non abused controls. Ogloff's Victorian study is among the best in the literature, with a 45 year follow up period, data linking across multiple data sets including policing, corrections, and health, and it is meticulously analysed.

In a subsequent conference presentation based on the 2012 study, Ogloff (2013) reported that 75% of children who had been victims of CSA reported no adverse effect, despite a long follow up period. His results are startling as, it is understood this was the first study to suggest that a majority of children who were victims of sexual abuse did not go on to demonstrate adverse symptoms in response to that abuse. However, the reliance on survivors being represented in health, police or child welfare databases means that a percentage of young people experiencing difficulties but not seeking help will be missed. This risk of negative outcomes was higher for those who were over the age of 12 at the time of being sexually abused as well as those who were penetrated in the course of being sexually abused.

In their 2013 review, Cashmore and Shackel delineated a range of symptoms experienced by CSA victims and survivors, divided into short term and long-term effects. Short-term effects can be prevented from turning into long term effects by timely and appropriate interventions. They reviewed findings that suggested CSA victims have elevated risks of both suicide and accidental deaths by overdose, in addition to drug and alcohol concerns, eating disorders, anxiety disorders, depression, and conduct disorders. All of these factors my colleagues and I have seen occur in our work with children and adults with histories of CSA. Research, where controls and comparison groups have been used, has consistently shown that the odds that a CSA survivor will experience elevated risk of the aforementioned problems is higher, often many times higher, than for comparison groups.

Perpetrators

When considering perpetrators, the notion that perpetrators are predatory, have strongly deviant interests sexually, are psychopathic, or serial offenders is mostly untrue and a function of public hysteria and sensationalised media reporting. There are predatory offenders who account for a large number of individual victims, but the majority of offenders are not particularly sexual deviant, do not fit classifications for diagnoses of paedophilia, and vary in their anti-sociality (Smallbone & Wortley, 2001). Contrary to public opinion sexual offenders have generally low rates of sexual recidivism, and over the last 20 years a steady decrease in recidivism rates by sexual offenders has been observed (Helmus, Hanson, & Thornton, 2009). However, profiling approaches to offenders have identified a class of offender with likely high rates of recidivism, that is, extra-familial offenders with male victims who meet criteria of paedophilia (Richards, 2011). Such offenders are in the minority of sexual offenders.

Treatment

Treatment rates for sex offending suggest a small but beneficial impact exists for treatment, and that for more serious offenders behavioural and pharmacological treatment combined provide better outcomes than either approach alone (Lösels & Schumucker, 2005; Nunes, Babchishin & Cortoni, 2011). Treatment rates for low-risk offenders are difficult to establish, as the re-offence rate is already so low for this group, that showing a genuine reduction in further offending in this group compared to chance is extremely difficult. Treatment is, however, a necessary plank in the management of sex offenders, although it cannot stand-alone. However, a failure to put resources into treatment, both in gaol and in the community, reduces the overall effectiveness of any response to sex offending.

Incarceration

A complexity involved in considering the issue of incarceration of serious offenders is the growing body of research that shows that incarceration is not a particularly effective deterrent for a large minority of offenders (Crank & Brezina, 2013). Incarceration can serve the purpose of incapacitation, and protection of the community, but equally can serve to criminalise a low-risk offender and increase the likelihood of the development of criminal attitudes in someone not initially programmed in that fashion (Andrews & Bonta 2007; Byrne & Taxman, 2006; Gendreau, Goggin, Cullen, & Andrews, 2000; Smith, Goggin & Gendreau, 2002). A balance between incarceration and rehabilitation is necessary as a crime prevention approach.

Risk assessment & management

The sentencing principle may need to consider the use of risk assessment as a means to guide sentencing, to avoid a 'one size fits all' approach. Low risk offenders, which make up 60 to 70% of all offenders (Helmus et al., 2009), are more likely to benefit from rehabilitative strategies than incarceration (Andrews & Bonta, 2007), and as their risk of recidivism is low to start with, incarceration as a means to protect society needs to be weighed against competing principles of jurisprudential action and consideration of human rights (Birgden, 2007). For instance, unless a 'lock them up and throw the key away' sentence is involved even serious offenders will eventually be released in to the community. Often their release is delayed however due to concerns about risk or treatment completion. The delays result in limited lengths of time left on the offenders' sentences which in turn results in less time to meet the offender's treatment needs, supervise their adjustment to non custodial environments, and manage their life-style risks. Incarceration may remain a viable option in terms of general deterrence or punishment, but has little specific deterrence value for most low risk offenders, as their likelihood of re-offence is low to start with. Incarceration also does little in terms of addressing offence-related risks (Gendreau et al., 2000). High-risk offenders, on the other hand, are difficult to treat and whilst studies suggest there is some real benefit to treatment (Wilson & Tamatea, 2013), incarceration needs to be combined with both in-gaol and post-release treatment and post-release supervision.

In recent years there has been a solid push for 'get tough on crime' initiatives and, being perhaps the most publicly unpalatable of criminals, sex offenders have borne the brunt of this. This has brought about a range of harsh and restrictive sentencing and management sanctions for sex offenders which have been instituted under the guise of community protection (Birgden, 2007; Centre for Sex Offender Management, 2008; Gendreau et al., 2000). However, the vast majority of sex offenders are managed in the community and even those who are incarcerated, will eventually return to life in the community. Therefore, whatever treatment occurs in prison is at best hypothetical, as the offender is at-risk all the time in the community and therefore, must actively practice their safety management and self-regulation strategies. Ideally, this would occur within a supportive and therapeutic environment. However, the reality is that with the lack of funding and available services, in addition to the recent community-based management initiatives for sex offenders, this is unlikely to occur.

The current model of incarceration followed by release with little post-release planning other than supervision and community-based management and control strategies has not demonstrated any significant or consistent

effect on recidivism (Gendreau et al, 2000; Gendreau, Goggin & Smith, 2000, as cited in Smith et al., 2002) and in fact, may place offenders under increased pressure, increasing their dynamic risks for recidivism (Petrunik, 2002; Seidler, 2010; Wilson, McWhinnie, Picheca, Prinzo, & Cortoni, 2007). An appropriate care model designed around interagency cooperation and communication meeting the supervision, treatment, accommodation and employment needs of offenders upon release needs to be considered (Wilson, 2013). Although pessimism is usually expressed about the treatment efficacy with serious offenders, especially those assessed as psychopathic (Salekin, 2002), intensive treatment models in gaol and extending into the community have been found to be more successful than previously thought (Wilson, 2013; Wilson & Tamatea, 2013). However, current resources in New South Wales seem stretched and unable to provide the resources to action such a model.

There is a tension between risk assessment and serious offending. For instance, a person who commits a serious offence of penetrative sexual behaviour against a minor may paradoxically be assessed as low risk. This is because if the offender is an older person, has been successfully married or in a defacto relationship for several years and has no prior criminal record they may be low risk irrespective of the severity of the offence. It is difficult to walk the line between considering objective offence severity (and likely public response to the offence) and risk for likely future offending. Treating all serious offences as the same, irrespective of risk is likely to produce a punitive approach that has little impact on future offending (as noted low-risk individuals do not tend to re-offend). Greater attention needs to be placed on the assessment of offenders who have committed a serious offence, so as to differentiate between high- and low- risk offenders, and a sentencing regime capable of responding to this variation in risk needs to remain in place so as to be responsive to rehabilitative needs and community protection requirements. A sentencing structure that allows for trading off time in gaol for time spent in the community and in treatment will maximise safety issues and rehabilitative approaches for a large number of offenders. Judicial discretion in sentencing is required in order to tailor sentences to the unique aspects of the particular offender's situation.

A large number of sentenced sex offenders (mostly low-risk offenders) will either spend the majority or the whole of their sentence in the community. There are currently few accredited rehabilitation and treatment resources for offenders, and long waiting lists for those that exist (Seidler & Nasr, 2013). Parole orders often include requirements for treatment, but without the means to effectively locate or resource such treatments, offenders who might be eligible for parole have to remain in gaol or enter the community without appropriate rehabilitation. The need to ensure appropriate

community-based services, either through an expansion of probation and parole and forensic psychological services, or through private/government partnerships and funding agreements needs to be considered. Currently, the Medicare Allied Health initiative does not allow for forensic treatment and costs for private treatment are prohibitive for many offenders and discourages treatment seeking.

The closure of community-based programs in New South Wales such as Cedar Cottage, will mean more pressure on the criminal justice system and post release treatment resources that to date, are not able to be adequately accessed. A major concern raised with the closure of diversion programs is the likelihood that many offenders, who are currently provided with an incentive to accept their guilt, will plead not guilty in order to avoid imprisonment. This will result in a lengthy trial process and, in the worst case scenario, the traumatising of the non-offending parent of an abused child, or even the child, by the requirement to give evidence against their partner or parent in open court (Eastwood, Patton & Stacy, 1998). To date, conviction rates in such scenarios are extremely low, with high rates of collapse of cases (Richards, 2011) thus raising the spectre that paradoxically, a 'hard line' on preferring prosecutorial to diversion approaches increases the number of untreated and unpunished sex offenders in the community.

As the treatment and rehabilitation of sex offenders is a specialised area, consideration should be given to maintaining an accreditation system such as The Commission for Children and Young People's Child Sex Offender Counsellor Accreditation Scheme (CSOCAS) in NSW. There is a need to ensure expert treatment when treatment is applied. There are specific skills in treatment delivery to sex offenders that are poorly understood by people without access to appropriate training and ongoing supervision (Marshall, Marshall, Serran, & Fernandez, 2006). An accreditation scheme such as CSOCAS ensures the maintenance of appropriate level of skill and training in the treatment community.

As a large number of offenders are young people and young people have considerably lower recidivism rates than adults (Nisbett, Smallbone & Wortley, 2010), concerns are expressed about the use of the sex offender register as a means to manage young people. The effect of using a register for low-risk young people is to truncate their entry into meaningful adult roles and create a stigmatising effect that is antithetical to the development of identity of young people. The use of the Child Protection Register (CPR) should be retained only for the highest risk young people. Conversely, it has been argued that the treatment needs for young offenders are higher than for older offenders, and that higher deterrence from future offending can be

achieved by treating young offenders (Smallbone, 2006). In any case, if a CPR registration is required, in order to prevent vigilantism such registers should remain confidential documents not available to the public.

A key issue remains public attitudes to sex offenders. It remains the case that public attitudes are more informed by crime shows and sensational media reports than by an understanding of the true nature of sex offending in our community (Greer, 2003). For instance, many in the public think there is a high not a low rate of recidivism for sex offenders, or that predatory sex offenders are the norm (the 'white van' effect) rather than most offenders being within the family home or people close to family. Thus, a need exists for leadership in the community to de-sensationalise stories about sex offending and to recognise that stigmatising a group of people rarely leads to successful rehabilitation of that group.

Conclusion

Despite the observed reduction of child sex abuse crimes in the United States (Finkelhor & Jones, 2006), there is no data to assess shifts in proclivity to abuse in Australia. It is acknowledged that every child harmed by sexual abuse is a tragedy. Although no system can deliver perfect safety for all children, a system should try to provide the best possible means to prevent re-offending.

It is thought that most sexual abuse crimes go unreported, making it difficult to genuinely assess prevalence in the community. A need exists to balance incarceration, supervision, and treatment/diversion responses to sex offending so as to reduce the likelihood of re offence in identified offenders, and to provide a social climate that can allow for the treatment and supervision of offenders that will encourage compliance. A focus on resourcing the treatment and supervision needs of offenders in addition to incarceration resources has to occur to adequately address the issue of sex offending in the community, once an offender has been identified.

Understanding that it is difficult to resource such a broad focus, a government/private partnership approach is probably best suited to provide the treatment needs for offenders in the community, given the current demand. In particular, there is a need to utilise risk assessment procedures in assessing the disposition of an offender, allowing judicial discretion on sentencing to reflect the need to balance deterrence, punishment, and rehabilitation.

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