Submission No 22

SENTENCING OF CHILD SEXUAL ASSAULT OFFENDERS

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NSW GOVERNMENT

Premier of New South Wales

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Mr Troy Grant MP
Chair
Joint Parliamentary Select Committee
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Mr Grant Troy,

Inquiry on sentencing of child sexual assault offenders

I write in response to the Joint Parliamentary Select Committee's call for submissions to the Inquiry on sentencing of child sexual assault offenders.

A factual submission has been prepared by the NSW Government and is attached for your consideration.

The Government looks forward to considering the Committee's report and recommendations on this important issue.

Yours sincerely

[redacted]

Barry O'Farrell MP
Premier

JOINT SELECT COMMITTEE

INQUIRY ON SENTENCING OF CHILD SEXUAL ASSAULT OFFENDERS

NSW Government Submission

INTRODUCTION

On 21 August 2013, a Joint Parliamentary Select Committee ("the Committee") was appointed to inquire into and report on whether current sentencing options for perpetrators of child sexual assault remain effective, and whether greater consistency in sentencing and improving public confidence in the judicial system could be achieved through alternative sentencing options including but not limited to minimum mandatory sentencing and anti-androgenic medication.

The Terms of Reference for the Inquiry require the Committee to have regard to:

a) Current sentencing patterns for child sexual assault
b) Operation of the standard minimum non-parole scheme
c) The experience of other jurisdictions with alternative sentencing options
d) NSW Law Reform Commission's Report 139 on Sentencing.

The content of the NSW Government submission provides factual information that will assist the Committee in assessing existing sentencing arrangements for child sexual assault offenders and their effectiveness.

The NSW Government acknowledges that this is the first stage of the Inquiry. Departments and agencies will be available throughout the Inquiry's proceedings to provide further information or clarification about existing or past government programs or initiatives, if required.

Contents

PART 1: BACKGROUND

Child sexual assault is a confronting and extremely serious form of criminal behaviour. Child sexual assault has devastating and lifelong consequences not only for the victims and their families but for society as a whole.

The Royal Commission into Institutional Responses to Child Sexual Abuse and the NSW Special Commission of Inquiry concerning the investigation of certain child sexual abuse allegations in the Hunter region are both highlighting the gravity and complexities of child sexual abuse and the fact that it remains a significant and challenging issue that as a community, we must be willing to do more about.

It is critical that safeguards are in place to reduce the likelihood of children being sexually assaulted. The NSW Government has an ongoing commitment to its statutory responsibilities to protect the safety and wellbeing of all children by responding to reports of child abuse and neglect, including child sexual assault.

In order to appropriately respond, it is necessary to understand:

- The prevalence of child sexual abuse
- The varied circumstances in which it might occur (e.g. within the family, by teachers and religious clergy; by strangers and on-line)
- The vulnerability of children at different ages, socially isolated families, children with disabilities and those from particular cultural backgrounds, noting the high prevalence of abuse in indigenous communities
- Why it occurs.

Where child sexual assault does occur, it is essential that the response processes in place appropriately reflect the seriousness of what has occurred and meet community expectations, in particular sentencing options and outcomes. This should include providing effective rehabilitation for child sexual assault offenders as a means of reducing reoffending.

There are also opportunities to improve the criminal justice system in how it responds to the victims of child sexual assault and their families. This includes making the system more child-friendly to minimise the risk of re-traumatisation, removing deterrents to reporting crimes and giving evidence and increasing and improving education and awareness of child sexual assault in the wider community.

Prevalence of child sexual assault in NSW

The Community Services Child Protection Helpline receives frequent reports of sexual assaults against children, as well as cases where children are deemed to be at significant risk of sexual assault in the future. In the twelve month period up to

31 March 2013, Community Services responded to 15,335 risk of significant harm reports (ROSH) where the primary reported issue was sexual abuse. This constituted 15 per cent of all ROSH reports over this period.[1]

When the Child Protection Helpline receives a report where there is evidence of physical indicators consistent with sexual abuse, the matter is referred to a Joint Investigation Response Team (JIRT) made up Family and Community Services (FACS), NSW Police and NSW Health professionals.

By working together as a JIRT, FACS, Police and Health officers provide a more effective investigative process and better understand each agency's role so the best outcome for the child or young person is achieved.

According to the NSW Bureau of Crime Statistics and Research (BOCSAR), over the two year period from January 2009 to December 2010:

- 495 offenders were convicted of child sex offences in NSW
- 98% of all offences were either aggravated child sexual assault or indecent child sexual assault (in this instance the list of offences defined as "aggravated sexual assault " include any sexual intercourse with a child under 16 years. For example, it includes both the offence of sexual intercourse against a child aged between 14-16 years in s66C(3) of the *Crimes Act 1900* ("Crimes Act") and the aggravated version of that offence in s66C(4))
- 97% of offenders were male
- 8% of offenders had prior sexual assault convictions within the past 5 years
- 75% of offenders convicted of aggravated child sexual assaults were given a prison sentence, with an average aggregate sentence of 5.5 years, serving a minimum term of 3.25 years
- 45% of offenders convicted of indecent child sexual assault were given prison sentences, with an average aggregate sentence of 2 years, serving a minimum term of 1.1 year.
- For this group, the likelihood of a prison sentence increased to 49% where there was one prior conviction (of any kind), and 82% where there were two previous convictions.[2]

The statistics referred to include cases of historic child sexual assault and incidences of consensual sexual intercourse between two young people of a similar age where one or both are under the age of 16. These kinds of cases tend to attract lower penalties. It should also be noted that historic child sexual assault offences carried far lower maximum penalties than the present offences.

[1] Community Services Quarterly Data Report, March 2012 to March 2013
[2] Holmes, J, BOCSAR, *Sentencing Snapshot Child Sexual Assault 2009-2010*, Issues Paper No.68 http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/bb68.pdf and further analysis from the Department of Attorney General and Justice.

Comparative BOCSAR data for the 10 year period from 2003 to 2012 shows the following:

- An upward trend in the percentage of people convicted of sexual assault imprisoned (up from 64.4% in 2003 to 78.5% in 2012) and the percentage of people convicted of child sexual assault imprisoned (up from 57.8% in 2003 to 77.9% in 2012)
- An upward trend in the average duration of imprisonment for child sexual assault (from 30 months in 2003 to 34 months in 2012)
- An upward trend in the proportion of offenders imprisoned for a child sexual assault offence compared with offences involving adult victims (up from 50% in 2003 to 66% in 2012). Child sexual assault offenders imprisoned now outnumber those who commit sexual assault offences against an adult victim.[3]

Impact of sexual assault on child victims

There is strong evidence to suggest that child sexual abuse has a number of adverse short-term and long-term impacts on the victim; including mental health and functioning, behavioural outcomes, interpersonal and social outcomes, educational outcomes, as well as physical health and brain development.

A 2013 study by Judy Cashmore and Rita Shackel[4], commissioned by the Australian Institute of Family Studies, reviewed the recent literature on the impact of child sexual abuse. Some of the key findings include:

- Significantly higher rates of suicide or accidental fatal overdose among child sexual abuse victims compared to the general population
- Studies of same sex pairs of twins have shown that, where one twin has experienced sexual abuse, this twin is much more likely to experience depression, alcohol and drug dependence and social anxiety
- After adjusting for demographic and socioeconomic correlates, child protection agency history was associated with several mental disorders
- Women who were sexually abused as children were more likely to engage in self-mutilation, risky sexual activity, abuse alcohol and drugs, and again become victims of sexual abuse.

The authors concluded that overall, there is “clear evidence” of links between child sexual abuse and a number of adverse outcomes for many children in adolescence and adulthood; and that these links remain even after taking other factors into account, including other forms of abuse and other adversities in childhood.

[3] NSW Criminal Court Statistics 2003-2012. It should be noted that for the purposes of these statistics, “child sexual assault offences” capture a broad range of offending behaviours.
[4] Cashmore J, Shackel R (2013), *The long-term effects of child sexual abuse*, Child Community Family Australia Paper No. 11

PART 2: CHILD SEXUAL ASSAULT OFFENCES

Sex offences against children are contained in Part 3, Divisions 10, 10A, 10B, 15, 15A and 15B of the Crimes Act. It contains offences which are aggravated if committed against a child as well as specific offences involving children. A range of behaviours are criminalised from acts of indecency through to full penetrative intercourse and penalties ranging from 2 years to life imprisonment.

The table below sets out the child sexual assault offences and the applicable maximum penalty in the Crimes Act. A standard non-parole period also applies to a number of these offences, as identified below.

Section	**Offence**	**Maximum penalty**
61J(2)	Aggravated sexual intercourse; circumstances of aggravation: victim under 16 years	20 years (snpp* 10 years)
61M(2)	Aggravated indecent assault; victim under 16 years	10 years (snpp* 8 years)
61N(1)	Act of indecency; victim under 16 years	2 years
61O(1)	Act of indecency; victim under 16 years and aggravated	5 years
61O(2)	Act of indecency; victim under 10	7 years
61O(2A)	Act of indecency; victim under 16; filmed for production of child abuse material	10 years
61P	Attempts to commit offences under s61J-61O – liable to same penalty	
66A(1)	Sexual intercourse child under 10	25 years (snpp* 15 years)
66A(2)	Sexual intercourse child under 10; aggravated	Life (snpp* 15 years)
66B	Attempt sexual intercourse with child under 10 or assault with intent	25 years
66C(1)	Sexual intercourse with child between 10-14	16 years
66C(2)	Sexual intercourse with child between 10-14; aggravated	20 years
66C(3)	Sexual intercourse with child between 14 and 16	10 years
66C(4)	Sexual intercourse with child between 14 and 16; aggravated	12 years
66D	Attempt to commit an offence under s66C or assault with intent liable to same maximum penalty	
66EA	Persistent child sexual abuse (3+ occasions)	25 years
66EB(2)(a)	Procuring a child for sexual activity; child under 14	15 years
66EB(2)(b)	Procuring a child for sexual activity; child 14+	12 years
66EB (2A)(a)	Meeting a child following grooming; child under 14	15 years
66EB(2A)(b)	Meeting a child following grooming; child 14 +	12 years
66EB(3)(a)	Grooming child under 14	12 years
66EB(3)(b)	Grooming child 14 or above	10 years
73(4)	Attempt for s73 offences liable to same penalty	
80A	Sexual assault by forced self-manipulation; aggravated where victim under 16 years	20 years
80D(2)	Causing sexual servitude of person under 18	20 years
80E(2)	Conducting sexual servitude business; person under 18	19 years

Section	Offence	Maximum penalty
80G	Incitement – liable to same penalty. Does not apply to ss61N or 61O where the offence constituted by inciting a person to commit an act of indecency. Does not apply to attempts or 66EA.	
91D	Promoting/causing child prostitution; child under 14	14 years
91D	Promoting/causing child prostitution child 14+	10 years
91E	Obtaining benefit from child prostitution; child under 14	14 years
91E	Obtaining benefit from child prostitution child 14+	10 years
91F	Premises used for child prostitution	7 years
91G	Use of child under 14 for child abuse material	14 years
91G	Use of child 14+ for child abuse material	10 years
91H	Production/dissemination/possession of child abuse material	10 years
91J	Voyeurism – aggravated where child under 16 years	5 years
91K	Filming person engaged in private act without consent for purpose of sexual gratification – aggravated where child under 16 years	5 years
91L	Filming private parts without consent for purpose of sexual gratification – aggravated where child under 16 years	5 years

*SNPP – standard non-parole period

Sexual intercourse is defined in s61H of the Crimes Act and includes penetration to any extent of the genitalia of a woman or the anus of any person. The definition also includes fellatio and cunnilingus.

Indecent assault is an act of indecency in the presence of the victim at the time or, immediately before or after an assault. An assault is either physical contact or a threat to the victim involving a reasonable apprehension of immediate and unlawful violence. The assault itself is indecent if it has a sexual connotation having regard to where the victim is touched or what part of the accused's body was used. If sexual connotation of the act is unclear, there must be an intention to obtain sexual gratification. If the assault took place separately to the act of indecency, the act of indecency must be in the presence of the victim. Indecent assault can include kissing, or touching of a person's breasts, bottom or genitalia.

Section 77 provides that consent of a child is not a defence to the offences under ss61E (1A), (2) or (2A), 61M (2), 61N (1), 61O (1), (2) or (2A), 66A (1) or (2), 66B, 66C, 66D, 66EA, 66EB, 67, 68, 71, 72, 72A, 73, 74 or 76A or, if the victim is under the age of 16 years, offences under ss61E (1), 61L, 61M (1) or 76. This means that if an offender is prosecuted under these child specific offences, the prosecution does not have to prove the child consented. The prosecution may still, however, lay a charge under s61J and establish a lack of consent for conviction.

The elements and structure of these offences have implications for the assessment of the seriousness of the offence and the sentence imposed. It also has implications for the collection and analysis of statistics of sentences imposed for these offences.

The 38 child sexual assault offences in the Crimes Act refer to different age groups and encompass an extremely broad spectrum of offending behaviour. There are a number of offences which criminalise sexual intercourse with a child under 16 - ss61J(2), 66A(1), 66A(2), 66C(1), 66C(2), 66(3) and 66(4).

There are a number of sex offences that can apply to both adults and children.

Child sexual assault offences capture a spectrum of offending behaviour. While all child sexual assault offences are serious, within the spectrum there are more serious and comparatively less serious instances of offending. An assessment of the objective seriousness of the offence is fundamental to sentencing.

PART 3: CURRENT SENTENCING ARRANGEMENTS FOR CHILD SEXUAL ASSAULT OFFENDERS

In NSW, sentencing is governed by the maximum penalty of the offence, the *Crimes (Sentencing Procedure) Act 1999* ("CSP Act") and the common law.

Sentencing is generally an exercise of judicial discretion except where a mandatory sentence applies (e.g. for the murder of a police officer s19B, Crimes Act). In exercising that discretion, the sentencing judge must make findings about the facts of the offence and the circumstances of the offender. The sentencing judge then applies the sentencing principles in the CSP Act and the common law to those findings and determines the appropriate sentence.

There is no single appropriate sentence in each case, rather a sentence will be imposed that is within the range of an appropriate sentence for that offence having regard to the circumstances of the offender (see Markarian v The Queen (2005) 228 CLR 357).

Purposes

The purposes of sentencing are set out in s3A of the CSP Act:

a) to ensure that the offender is adequately punished for the offence,
b) to prevent crime by deterring the offender and other persons from committing similar offences,
c) to protect the community from the offender,
d) to promote the rehabilitation of the offender,
e) to make the offender accountable for his or her actions,
f) to denounce the conduct of the offender,
g) to recognise the harm done to the victim of the crime and the community.

These purposes are not ranked or prioritised and all have equal application (Muldrock v The Queen (2011) 244 CLR 120).

General Principles

The following principles apply generally to sentencing in Australia:

- instinctive synthesis approach, which requires the sentencing judge to identify all the relevant factors, assess their significance and make a value judgment on the appropriate sentence (Muldrock v The Queen; Markarian v The Queen)
- the maximum penalty is a sentencing yardstick that must be given careful attention (Markarian v The Queen)
- the sentence imposed must be proportionate to the offence and the circumstances of the offender (Veen v The Queen (No. 2) (1988) 164 CLR 465)

- equal justice requires that like cases be treated alike and differential treatment of persons according to the difference between them (Green v The Queen; Quinn v The Queen (2011) 244 CLR 462)
- consistency in sentencing means the consistency in the application of relevant legal principles, not some numerical or mathematical equivalence (Hili v The Queen; Jones v The Queen (2010) 242 CLR 520).

Sentencing Options

Before imposing a custodial sentence, the court must first be satisfied that no other sentence is appropriate under s5(1) of the CSP Act.

Non-custodial options

A number of non-custodial sentencing options are available under the CSP Act. The Court may:

- dismiss the charge under s10(1)(a)
- dismiss the charge and impose a good behaviour bond of up to 2 years under s10(1)(b)
- dismiss the charge and order the offender participate in an intervention program under s10(1)(c)
- record a conviction and impose no other penalty under s10A
- impose a good behaviour bond of up to 5 years under s9
- impose a fine on an offender under Part 2 of Division 4
- impose a community service order for a set number of hours depending on the maximum penalty for the offence under s8.

Certain conditions apply to good behaviour bonds and community service orders under the CSP Act and the court may impose additional conditions as it considers appropriate.

Custodial options

If the court is satisfied that a custodial sentence is warranted, the court can impose a sentence of imprisonment that lasts until the court adjourns, a suspended sentence, a home detention order, an intensive correction order or full time imprisonment.

A court can sentence a person to a term of imprisonment that lasts until the court adjourns. It is a custodial sentence because the person is detained until the court's next adjournment and is usually used where the person has already spent a sufficient or excessive period in custody before being sentenced. This is rarely used and the NSW Law Reform Commission has recommended it be removed as a sentencing option in NSW.

If the court imposes a sentence of up to 2 years imprisonment, the court may suspend the execution of the sentence on the condition that the offender enters into a good behaviour bond under s12 of the CSP Act. If the bond is breached, the court can revoke the bond and the offender must serve the sentence of imprisonment unless the court imposes an intensive correction order or home detention. The standard conditions of the bond require the person to be of good behaviour and appear before the court when required to do so. The court may impose additional conditions on the bond.

A court that imposes a sentence of up to 18 months can order that it be served by way of home detention. Home detention means the offender is detained in his or her home. A number of standard conditions apply to a home detention order and the court can impose additional conditions. Home detention is, however, not available as a sentencing option for offenders convicted of sexual offences involving children under s76 of the CSP Act.

Where a court sentences the person to a term of imprisonment for up to 2 years, it can order that it be served by way of an intensive correction order. A number of standard conditions apply to a intensive correction order and the court can impose additional conditions. Again, however, intensive correction orders are not available for offenders convicted of offences under Part 3 Divisions 10 and 10A of the Crimes Act under s66 of the CSP Act. This applies to offences from s61I to s80F of the Crimes Act.

When sentencing an offender to a term of full time imprisonment, s44(1) of the CSP Act requires the court to first set the non-parole period. The balance of the sentence must not exceed one-third of the non-parole period unless there are special circumstances for it being more (s44(2) CSP Act). This means that the non-parole period is 75% of the total sentence and that the court may reduce this ratio, but not increase it.

The non-parole period is to be determined by reference to the minimum time the offender should serve having regard to the circumstances of the offence and circumstances of the offender (Bugmy v The Queen (1990) 169 CLR 525).

Sentencing for more than one offence

When sentencing for more than one offence, the court can either set a sentence for each offence and order that these be served consecutively, concurrently, or partly cumulatively. Sentences are structured by adjusting the commencement date of each sentence as provided for by s47(2)(a) of the CSP Act.

If the judge sets separate sentences for each offence, the principle of totality requires the judge to consider whether the sentences should be served consecutively, concurrently or partly cumulatively and then determine whether the total sentence is just and appropriate (Johnson v The Queen (2004) 78 ALJR 616, Mill v The Queen (1988) 166 CLR 59). Whether a sentence should be served concurrently or

consecutively involves the application of the principles in R v XX (2009) 195 A Crim R 38. The sentence imposed must always reflect the criminality of all the offences.

Child sexual assault offending can raise difficulties in the proper application of the totality principle. Some cases may involve a series of sexual acts that occur in a single event, others may involve a continuing and extended course of conduct. Consideration will need to be given to the number of victims involved, the duration of the offence or offences, and the extent of the sexual acts (R v Davis [1999] NSWWCCA 15).

Where the child sexual assault consists of multiple assaults occurring in the context of continuous abuse, the fact that the offences are not isolated events is a material consideration on sentence: Dousha v R [2008] NSWCCA 263.

Alternatively, the court can set an aggregate sentence under s53A of the CSP Act. If the court sentences the offender to an aggregate sentence it must state that an aggregate sentence is being imposed and the sentence that would have been imposed for each offence had an aggregate sentence not been imposed.

Aggravating and Mitigating Factors

Section 21A of the CSP Act sets out a number of aggravating and mitigating factors that are to be taken into account on sentence. Section 21A(2) prohibits the court from having any additional regard to an aggravating factor set out in s21A(2) if it is an element of the offence.

Aggravating factors in CSA offences

A number of aggravating factors in the CSP Act may be relevant when sentencing for child sexual assault offences:

- the offender has a record of previous convictions: s21A(2)(d)
- the offence involved gratuitous cruelty: s21A(2)(f)
- the injury, emotional harm, loss or damage caused by the offence is substantial: s21A(2)(g)
- the offender abuses a position of trust or authority in relation to the victim: s21A(2)(k)
- the victim is vulnerable, for example, because the victim is very young or has a disability: s21A(2)(l)
- the offence involves multiple victims or a series of criminal acts: s21A(2)(m)
- the offence was part of a planned or organised criminal activity: s21A(2)(n).

That the offence involved multiple victims or a serious of criminal acts, or was part of a planned or organised criminal activity generally arise in relation to grooming offences in s66EB, the sexual servitude provisions in ss80D and 80E, the child prostitution provisions in ss91D-91F and child pornography offences in ss91G-91L of the Crimes Act.

Victim impact statements

A court may receive and consider a victim impact statement when sentencing an offender under s28(1) of the CSP Act. The weight that is to be given to a victim impact statement is a matter for the court. It has been held that the statement may be relevant to establish the subsequent effects on the victim: R v Thomas [2007] NSWCCA 269.

Breach of trust

The aggravating factor of a breach of trust is common in child sexual assault offences. It has been held that child sexual assault by a father or a family member of the victim is the most serious breach of trust (R v BJW (2000) 112 A Crim R 1, R v Hudson (unrep, 30/7/98, NSWCCA)). A breach of trust has been held to have occurred where the offender was a teacher or coach (R v King (unrep, 20/8/91 NSWCCA), R v Lumsden (unrep, 31/7/96 NSWCCA)), a babysitter (R v Eagles (unrep, 16/12/93, NSWCCA), a priest (Ryan v The Queen (2001) 206 CLR 267), and where the offender took advantage of a victim's dysfunctional background and homeless state (R v Fisk (unrep, 21/7/98, NSWCCA)).

Mitigating factors in child sexual assault offences

Section 21A(3) sets out the mitigating factors on sentence. The application of these factors is dependent on the circumstances of the case.

Prior good character

Section 21A(5A) provides that when sentencing for a specified child sexual assault, the good character and lack of previous convictions of an offender <u>are not to be taken into account</u> as a mitigating factor if the court is satisfied that the factor assisted the offender in the commission of the offence.

This provision applies to the following offences:

a) An offence against section 61I, 61J, 61JA, 61K, 61M, 61N, 61O or 66F of the Crimes Act where the person against whom the offence was committed was then under the age of 16 years, or
a) An offence against section 66A, 66B, 66C, 66D, 66EA, 66EB, 91D, 91E, 91F, 91G or 91H of the Crimes Act, or
b) An offence against section 80D or 80E of the Crimes Act where the person against whom the offence was committed was then under the age of 16 years, or
c) An offence against section 91J, 91K or 91L of the Crimes Act where the person who was being observed or filmed as referred to in those sections was then under the age of 16 years, or
d) An offence of attempting, or of conspiracy or incitement, to commit an offence referred to in any of the above paragraphs.

Where the offender has not used his previous good character to commit the offence as required by s21A(5A), the courts have held that an offender is not entitled to leniency on the basis of good character where there has been repeat offending.

Offender abused as child

If an offender can demonstrate that he or she was sexually abused as a child and that history has contributed to the offending, then that can be taken into account as a mitigating factor (R v AGR (unrep, 245/07/98, NSWCCA). However, it is not to be taken into account as an excuse (R v Reynolds (unrep, 7/12/98, NSWCCA). The weight to be given to the offender's sexual abuse as a child will depend on the facts of the case and may affect the offender's moral culpability or prospects of rehabilitation.

Delay

It is common that child sexual assault offences are not reported immediately and in some cases there is substantial delay between the commission of the offence and the date of sentence. This delay can be relevant in a number of ways (R v Todd [1982] NSWLR 517]). First, it can make the offence more difficult to prove or the offender may be put at a forensic disadvantage due to the deterioration of memories. Second, during the intervening period, the offender may have demonstrated significant rehabilitation and not re-offended. Third, the offender's ill health or age may justify a degree of leniency.

The weight to be given to the delay on sentence will depend on the particular facts of the case, the reasons for the delay and evidence of the offender's situation. The mere passage of time does not mitigate the penalty (R v Dennis (unrep, 14/12/92, NSWCCA) and there must be some demonstrable unfairness caused to the offender before the delay can be taken into account (R v Johnson (unrep, 16/05/97, NSWCCA).

Extra curial punishment

Sentencing judges can take into account extra-curial punishment as a mitigating factor, for example abuse, harassments and threats (R v Allpass (1993) 72 A Crim R 561). Extra curial punishment was taken into account where an offender had been the subject of personal harassment and received a large volume "hate mail" from members of the public (R v Holyoak (1995) 82 A Crim R 502)).

Hardship in custody

That an offender will have to serve his or her sentence in protective custody is not automatically regarded as a mitigating factor on sentence (Clinton v R [2009] NSWCCA 276). If the offender can show that the conditions of imprisonment will be more onerous for him, then that will be taken into account and it is for the offender to lead evidence to establish that hardship (Clarkson v R (2007) 171 A Crim R 1). For

further discussion on this subject, please see the Sentencing Council's Report on Penalties relating to sexual assault offences in NSW (Vol 1) 2008.

Consent

The consent of a victim is not a mitigating factor when sentencing for child sexual assault offences.

Early guilty pleas and providing assistance to authorities

A court is to take into account an offender's guilty plea and the timing of that plea under s22 of the CSP Act. The discount to be given for a guilty plea is determined by the guideline judgment in R v Thomson & Houlton (2009) 49 NSWLR 383. The discount to be allowed for a plea of guilty should generally be in the range of 10%-25%.

The discount for a guilty plea is to reflect the offender's remorse or contrition as demonstrated by his or her guilty plea, the utilitarian value of the plea to the efficiency of the criminal justice system and the particular value in avoiding the need to call witnesses, especially victims in sexual assault cases or crimes involving children.

A court may impose a lesser penalty having regard to assistance given by the offender to law enforcement authorities in the prevention, detection, investigation or proceedings in relation to the offence concerned or any other offence under s23 of the CSP Act. The court is required to specify the discount allowed for assistance to authorities, which is combined with the discount for a guilty plea.

Standard non-parole period scheme

Presently, only four offences associated with child sexual assault are included in the standard non-parole period scheme. They are identified in the table set out in Part 2 of this submission.

The High Court in Muldrock v The Queen (2011) 244 CLR 120 overruled R v Way (2004) 60 NSWLR 168 and held that the standard non-parole period is to be used as a legislative guidepost when determining sentence. The guidepost reflects the non-parole period for an offence in the middle of the range of objective seriousness, which is to be determined without reference to the characteristics of the offender. The court is not permitted to engage in a two stage process where it asks whether the offence falls within the middle of the range by comparison with a hypothetical mid-range offence and, if it does, whether there are reasons to justify imposing a longer or shorter non-parole period.

The Joint Select Committee on sentencing of child sexual assault offenders has been provided with the Sentencing Council's interim report on standard non-parole periods and sexual offences against children. The Council has identified a number of offences as suitable for inclusion in the standard non-parole period scheme.

The NSW Law Reform Commission's report 139 on Sentencing

The NSW Law Reform Commission's report 139 on Sentencing was tabled in Parliament on 12 September 2013. The Law Reform Commission recommended a revised Sentencing Act to streamline the provisions aimed at simplifying and promoting transparency in sentencing. The Law Reform Commission also recommended changes to the sentencing options available to the court.

The Law Reform Commission recommended replacing the list of aggravating and mitigating factors in s21A of the CSP Act with a number of factors that should be considered by the court. The replacement provision can be found in Recommendation 4.2 and, as the Commission noted, the proposed provision would cover many of the principles set out in s21A of the CSP Act.

The Commission also recommended retaining s21A(5A) and (6), which prohibit a court from taking into account an offender's good character if it is satisfied that it assisted the offender in committing the CSA offence. The Commission recommended that this prohibition should not apply to juvenile offenders.

The Commission recommended retaining s24A of the CSP Act which provides that the registration and supervision requirements that apply to convicted child sexual assault offenders are not to be taken into account as a mitigating factor on sentence.

The Law Reform Commission also recommended that if home detention and intensive correction orders are retained in the revised Sentencing Act, then offenders convicted of offences under Part 3 Divisions 10 and 10A of the Crimes Act where the victim is under the age of 16 years and the offence carries a maximum penalty of more than 5 years should be ineligible for these orders. This applies to offences from s61I to s80F of the Crimes Act, but not to ss61N(1) and 61O(1). This exclusion is reflected in the Commission's recommendations for a new community detention order.

The NSW Government is considering the Law Reform Commission's report on sentencing.

Historic child sexual assault offences

In a large number of child sexual assault cases, there is a delay between the commission of the offence and the date the offender is sentenced. This is due to the nature of the offending and the age of the victim at the time of the offence. Currently there is a focus on encouraging victims of child sexual assault to report, however, this was not always the case. This means that there are now a number of offenders coming before the courts for child sexual assault offences committed in the 1950s-1990s.

When sentencing for historic offences, the Court has regard to the scope of the offence and maximum penalty for the offence at the time the offence was committed. The court is also to take into account the sentencing practice and patterns for the offence at the

time of the offence when the sentencing practice has moved adversely to the offender: R v MJR (2002) 54 NSWLR 368. However, it is for the offender to demonstrate that the sentencing practice was more lenient at the time of the offence through the use of statistics and cases.

Courts have noted on a number of occasions that since the 1980s there has been an increase in sentences, including the prescribed maximum penalties, for child sexual assault offences (see for example, Magnuson v R [2013] NSWCCA 50). On 1 February 2003, the standard non-parole period was introduced and at that time there was an increase in the maximum penalty for s66A (sexual intercourse with a child under 10) from 20 years to 25 years imprisonment with a standard non parole period of 15 years. It should also be noted that before 1981, indecent assault encompassed a range of sexual acts which would now be defined as sexual intercourse in the Crimes Act.

The Judicial Commission has published a number of research reports relating to sentences imposed for child sexual assault offences over the years and a report on the impact of the standard non-parole period on sentencing patterns. The titles and references for these reports are set out at the end of this submission.

For the reasons outlined above, care must be taken when analysing statistics on sentences imposed for child sexual assault offences to ensure the statistics do not include historic offending which will invariably reduce the median and average sentences imposed.

The heterogenous nature of offenders convicted of child sexual assault offences

As with all offences, there is no one type of offender who commits child sexual assault offences. Very few adults who sexually offend meet the diagnostic criteria for paedophilic disorder, and even fewer adolescents who are charged with child sexual assault offences meet the criteria, which include being at least 16 years old. There are many differences amongst child sexual assault offenders including:

- number of offences committed
- whether offences committed over a long period of time or in one episode
- different types of sexual acts committed
- whether the offences involved one single victim or multiple victims
- age of the offender
- age of victim[5].

Application of existing offence provisions to young offenders

In the last 12 months 4037 young people have entered custody on either remand or control and of these, 32 or 0.8% entered custody for child sexual assault offences.

[5] Dr Karen Gelb, *Recidivism of Sex Offenders Research Paper* (2007) Sentencing Advisory Council (Victoria)

Juvenile Justice works with young people who have been charged with child sexual assault offences to provide specialist assessments regarding risk of re-offending and treatment needs. If they are found guilty they are generally required to attend a specific sexual offending treatment program.

The child sexual assault offences in the Crimes Act capture consensual sexual acts occurring in relationships involving two young people close in age, where one or both persons is under 16 years. Consent is not a defence to the child sexual assault offences set out in s77 of the Crimes Act, including the sexual intercourse offences under s66C.

It should be noted that the procuring and grooming offences do not apply to offenders under 18 years of age.

Victoria, Tasmania, Western Australia and the Australian Capital Territory all have what is referred to as a "similar age" defence which allows consent to be used as a defence when the victim and the accused are certain ages.[6] These jurisdictions have differing thresholds for the defence to apply. A recent scoping study by BOCSAR indicated that of 382 finalised non-historic child sexual assault offences identified for 2012, 45 involved young people of a similar age who engage in consensual sexual intercourse.

Advances in technology and the ubiquity of smart phones with cameras and video recording capabilities have meant that young people who send sexual images of themselves or others to other people, are committing child pornography offences in the Crimes Act. The Victorian Government recently adopted the recommendations of a Parliamentary Inquiry into Sexting that minors, who make, possess or disseminate sexually explicit images or video of themselves or their peers cannot be charged with child pornography offences.

It is noted that a young person can be dealt with under the Young Offenders Act 1997, which includes diversionary measures, for a limited number of child sexual assault offences.

There is often an assumption that those found guilty of child sexual assault offences are more likely to pose a risk for persistent sexual violence. There is extensive research indicating that most young people who sexually assault children are not on a trajectory to become adults who sexually offend. Dr Wendy O'Brien from the Australian Crime Commission observes that although there is an under-acknowledgement of this issue in Australia there is a large body of international scholarship on juveniles who exhibit sexually violent or coercive behaviours toward other juveniles.[7]

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[6] Section 45 of the *Crimes Act 1958* (Vic), s124 of the *Criminal Code Act 1924* (Tas), s55 of the *Crimes Act 1900* (ACT), s321 of the *Criminal Code Act Compilation Act 1913* (WA).

[7] Recent major reports include: Mullighan, E.P. (2008); Wild, R. and P. Anderson (2007); Ella-Duncan, M., et al. (2006); Crime and Misconduct Commission (2004); Gordon, S., K. Hallahan, et al. (2002); and Robertson, B. (1999).There are a number of extensive studies on Canadian Aboriginal youth sex offenders.

The evidence shows that young people, who do re-offend, are unlikely to commit further sexual offences. Two large scale follow-up studies of Australian adolescents who were charged with sexual offences have been published in the peer-reviewed literature.[8] Both had very similar findings, with adult sexual recidivism rates being 9.5% and 9% respectively and adult non-sexual recidivism rates being 66.3% and 61% respectively. These findings have been replicated overseas.[9]

[8] Allan, A., Allan, M. M., Marshall, P., & Kraszlan, K. (2003). Recidivism among male juvenile sexual offenders in Western Australia. *Psychiatry, Psychology and Law, 10*(2), 359-378; Nisbet, I. A., Wilson, P. H., & Smallbone, S. W. (2004). A prospective longitudinal study of sexual recidivism among adolescent sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 16*(3), 223-234.

[9] Caldwell, M. (2007) Sexual offense adjudication and recidivism among juvenile offenders. *Sexual Abuse: A Journal of Research and Treatment, 19*, 107 – 113; Vandiver, D. M. (2006). A prospective analysis of juvenile male sex offenders: Characteristics and recidivism rates as adults. *Journal of Interpersonal Violence, 21*(5), 673-688.

PART 4: ALTERNATIVE SENTENCING OPTIONS AND DIVERSION

The Committee has been asked to explore alternative sentencing options for child sexual assault offenders including but not limited to mandatory minimum sentences.

Mandatory Minimum Sentences

In NSW, mandatory minimum sentences have been introduced for the following serious criminal offences:

- Murder of a police officer (s.19B, Crimes Act)
- Assault causing death when intoxicated (s.25A, Crimes Act).

On 26 February 2014, the Government also introduced to Parliament the *Crimes Amendment (Intoxication) Bill 2014* to bring effect to mandatory minimum sentences for certain serious personal violence offences where the offender is intoxicated in public.

The Government looks forward to considering the views of the Committee on this issue in relation to child sexual assault offences.

Diversion

Diversionary programs are a feature of many criminal justice systems including in Australia and are designed to provide benefit to the victim, offender and broader community. Diversionary programs enable eligible offenders to be diverted prior to trial or sentencing to receive appropriate assistance including rehabilitation, counselling and/or treatment.

Pre-Trial Diversion of Offenders Program

The *Pre-Trial Diversion of Offenders Act 1985* established the Pre-Trial Division of Offenders Program (also known as the Cedar Cottage Program) which was operated by NSW Health.

The Program's objectives were:

- To help child victims and their families resolve the emotional and psychological trauma they have suffered;
- To help other members of the offender's family avoid blaming themselves for the offender's actions and to change the power balance within their family so the offender is less able to repeat the sexual assault; and
- To stop child sexual assault offenders from repeating their offences.

The Program provided treatment to the victim and non-offending family members including family and individual support and counselling. In particular, there was a focus on strengthening the bond between the child victim and non-offending parent.

The Program was intensive and usually lasted for 2 years, however, in some cases this was extended to 3 years.

The *Pre-Trial Diversion of Offenders Regulation 2005*, which provided for referral and assessment of offenders to the Program, lapsed on 1 September 2012. Offenders charged after this date can no longer be referred to the Program. The Regulation was allowed to lapse as the NSW Government determined that the Program did not reflect community expectations in regards to the consequences of such serious offences against children.

PART 5: OTHER CONSEQUENCES OF A CONVICTION OF CHILD SEXUAL ASSAULT

A number of consequences attach to a conviction or a finding of guilt for a child sexual assault offence. These escalate in seriousness. Section 24A(1) of the CSP Act states that the court is not to take into account these consequences as a mitigating factor on sentence.

Child Protection (Working With Children) Act 2012

The *Child Protection (Working With Children) Act 2012* provides that a person cannot engage in child related work unless they have a working with children check clearance. A working with children check clearance cannot be given to a person who has been convicted of an offence in Schedule 2 of the Act if the offence was committed as an adult. Schedule 2 sets out a number of offences included child sexual assault offences. This only applies if the person was an adult at the time the offence was committed.

Child Protection (Offenders Registration) Act 2000

The *Child Protection (Offenders Registration) Act 2000* established the NSW Child Protection Register in October 2001. Under this Act, certain convicted child sex offenders and other persons who have committed serious offences against children are obliged to report personal information to the Police for set periods of time. Police are provided with information about registrable persons including where they live, any children they reside with, where they work and what car they drive. Registrable persons are prohibited from working with children. Police are able to enter and inspect any residence of a registrable person without notice to verify any relevant personal information reported by the person.

The registrable persons scheme applies to juveniles dependent on the offence they are convicted of. Young offenders are not registrable persons under the Act if they are convicted of a single offence involving an act of indecency or possessing or disseminating child pornography (see s3A of the Act).

Child Protection Watch Teams

The first interagency Child Protection Watch Team (CPWT) was established in 2004 on a trial basis in South West Sydney. This was the subject of an independent evaluation in 2007 which recommended that a co-ordinated state-wide approach be implemented. The state-wide roll out of the CPWT was completed in March 2010.

The CPWT comprises of NSW Police Force (Chair), CSNSW, Juvenile Justice, FACS (Community Services, Housing NSW and ADHC), Department of Education and Communities, NSW TAFE Commission, Ministry of Health, Justice Health & Forensic

Mental Health Network, Office of the Public Guardian, Sydney Children's Hospital Network and a local health district constituted under the *Health Services Act 1997.*

The purpose of the CPWT is to protect the community from high risk offenders on the NSW Child Protection Register through multi-agency monitoring and risk management of certain high risk sexual and violent offenders against children, who are "registrable persons" within the meaning of the *Child Protection (Offenders Registration) Act 2000* and are living in the community. The CPWT also provides a formal structure for the interagency exchange of information in relation to certain high risk registrable persons.

The objectives of the CPWT are to:

- Collaboratively enhance the risk management of high risk registrable persons by ensuring that they are provided with the appropriate options and support necessary to ensure that any risk they may present to the community is minimised;
- Effectively utilise mechanisms for inter-agency information exchange to facilitate risk management of high risk registrable persons; and
- Provide an early warning system of inappropriate behaviours, associations, living arrangements and activities.

Child Protection (Prohibition Orders) Act 2004

The *Child Protection (Prohibition Orders) Act 2004* provides police with the ability to apply to the Local Court for a Prohibition Order to prevent registrable persons from engaging in specified conduct where there is a reasonable cause to believe the person poses a risk to the sexual safety or life of one or more children, or children generally. Prohibition orders can only be applied for 'registrable persons' within the meaning of the *Child Protection (Offenders Registration) Act 2000*.

The prohibition of high risk offenders from specified conduct previously shown to be a precursor to their offending, aims to prevent further serious offences before they are committed. Prohibition orders can be made against an adult registrable person for a period of up to 5 years. Contravention of a prohibition order carries a maximum penalty of 500 penalty units or imprisonment for 5 years or both.

Police can apply to the Local Court for a contact prohibition order preventing a registrable person from contacting co-offenders or victims where there are reasonable grounds to suspect that contact may occur. A contact prohibition order lasts for up to 12 months and the penalty for contravening a contact prohibition order is 50 penalty units or 12 months imprisonment or both.

Crimes (High Risk Offenders) Act 2006

The *Crimes (High Risk Offenders) Act 2006* provides for the extended supervision and continuing detention of serious sex offenders to ensure the safety and protection of the

community, and to encourage serious sex offenders to undertake rehabilitation. Continuing detention orders may be sought whilst an offender is in custody and extended supervision orders may be sought whilst an offender is serving a sentence.

Before making an order the Court must be satisfied that there is a high degree of probability that the offender poses an unacceptable risk of committing a serious sex offence.

A continuing detention order results in an offender remaining in custody upon the expiration of his or her term of imprisonment for a period of up to 5 years. An extended supervision order provides for the intensive supervision and monitoring of serious sex offenders in the community. An extended supervision order can be made for a period of up to 5 years and subsequent applications can be made. Breaching an extended supervision order is an offence which carries a maximum penalty of 2 years imprisonment or 100 penalty units or both.

PART 6: TREATMENT AND MANAGEMENT OF CHILD SEX OFFENDERS

In December 2012 there are 1277 sentenced sexual offenders in custody with a further 81 in custody who have yet to be sentenced. Approximately 870 of these offenders have current index convictions[10] for sexual offending. Approximately 26% of these sexual offenders in custody identify as Aboriginal or Torres Strait Islanders. Twenty-two of these sentenced offenders are female (1.7%). Approximately 5% of these offenders have an assessed developmental or intellectual disability. There are approximately 400 sexual offenders managed by CSNSW in the community across the state. These offenders include around 167 on parole and 233 who have received community sentences.

These figures overstate the number of offenders convicted of child sexual assault offences because sex offenders are defined broadly in the Corrective Services context as:

- Any convicted offender whose current offences include one of sexual violence,
- Any convicted offender whose history of offences includes a conviction for sexual violence,
- Any convicted offender who tells CSNSW that he/she has committed acts of sexual aggression (whether they be officially known or not, e.g., includes “no billed” charges), or
- Any convicted offender whose offence(s) are determined to have entailed an underlying motivation of sexual violence (sexually motivated murder, burglary with sexual violence as motivation, etc.).

A range of assessments of sexual offenders are completed by Sex Offender Programs psychologists at different stages throughout the offender’s sentence.

1. Pre-sentence assessments for the sentencing authorities/court.
2. Case management planning assessments completed shortly after the commencement of a sexual offender’s custodial sentence.
3. Pre-release assessments at the request of the State Parole Authority. These are completed prior to an offender’s earliest possible release date and assist the State Parole Authority to determine whether or not to release an offender and under what conditions.
4. Risk assessment/management assessments for probation/parole staff on how to best manage sexual offenders in the community.

[10] A current index conviction means a conviction for an offence for which they are presently in custody.

These assessments report on the following:

1. The offender's risk of committing further sexual offences
2. The appropriate intensity of sexual offender treatment program required and its availability
3. The individual treatment (criminogenic) needs of the offender and how these are best delivered
4. Recommendations for other treatment/interventions programs and services and its availability, and
5. Managing the offender's risk in the community upon release.

Custodial and Community-based treatment programs

There is evidence to suggest that effective treatment programs can also reduce the rates of sex offender recidivism.[11]

Prior to 1980, evaluations of psychological treatments for sex offenders showed that they had no or little effect on reducing recidivism. Treatment programs were psychotherapeutic in style and were aimed at offenders without gaining an insight into why they perpetrate sex offences.

Since the early 1980s, treatment programs have been refocussed, and now a greater emphasis on cognitive-behavioural therapy and relapse prevention. Cognitive behavioural therapy targets a range of criminogenic needs and teaches relevant skills in a manner appropriate for the learning style and receptivity of the individual offender. Relapse prevention teaches offenders to recognise risks for reoffending and provides them with mechanisms for avoiding this behaviour.

CSNSW has a range of custody and community based treatment programs available to sentenced sexual offenders. All CSNSW Sex Offender Programs are cognitive-behavioural therapy (CBT) based with an emphasis on the 'Good Lives' model promoting individual strengths to encourage no re-offending. All treatment programs are voluntary.

Essential features of CSNSW sex offender treatment programs include:

- An emphasis on continuity of treatment services throughout custody and in the community
- Separate programs to prepare/motivate, treat and maintain the treatment gains of sexual offenders.
- Programs are tailored to meet the needs of each participating sexual offender
- Programs vary in intensity according to the risk of re-offending and needs of the offender
- The content and structure of programs are based on up-to-date international research findings.

[11] Gelb K (2007), *Recidivism of Sex Offenders Research Paper*, Sentencing Advisory Council

- An emphasis is placed upon making programs culturally appropriate for Aboriginal sexual offenders.
- Innovative programs are implemented for specific sexual offenders (e.g., deniers and self-regulation [disability] programs)
- Psychologists treating sexual offenders receive a high level of supervision and support, and training from local and international experts.
- CSNSW sexual offender programs have been demonstrated to be effective at reducing sexual and non-sexual re-offending (see research and evaluation section below).

(a) Custodial Programs

An offender will be eligible for a custodial program if:

- The offender consents to undertake treatment
- The offender consents to being SMAP (Special Management Area Placement) status for the duration of their time in treatment. SMAP is a location or area within a centre where protective custody inmates may be housed following an assessment of their individual circumstances.
- The offender has a C (minimum) security classification (with the exception of CUBIT at Parklea CC).
- There is sufficient time remaining on their sentence to complete the treatment prior to their earliest possible release date (EPRD) or sentence expiry date should they already be past their EPRD.
- The offender's history indicates that they are able to function effectively within a treatment program without risk to self or others.
- The offender acknowledges some level of responsibility for their sexual offence(s) (with the exception of the Deniers Program).
- The offender is not appealing the conviction for which he is in custody.

Preparatory program for sexual offenders (PREP)

PREP is aimed at increasing an offender's motivation and/or readiness to participate in a sex offender treatment program. It is not a treatment program nor a pre-requisite for sex offender treatment.

Custody Based Intensive Treatment (CUBIT)

CUBIT is a therapy program for offenders who have sexually abused adults and/or children. The program is designed to help offenders change their thinking, attitudes, and feelings which led to their offending behaviour. Offenders are expected to take responsibility for their offending behaviour and their future, examine victim issues, identify how and why they offended, develop new strategies and skills to use in relationships and in coping with their emotions, and develop detailed self-management

plans to assist in their release planning. It is offered to moderate or high risk/needs sexual offenders and is a 6-10 month program with three sessions per week.

CUBIT Outreach (CORE)

CORE is a program for men who have sexually abused adults or children. Participants are expected to develop an understanding of and take responsibility for their offending behaviour; examine victim issues; identify their offence pathway; and, develop detailed self-management plans. It is for moderate-low risk sexual offenders and is 6 to 8 months in length, with 2 group sessions per week.

Deniers Program

The Denier Program is a program for men who have been convicted of sexually abusing adults or children but maintain they are innocent. The Deniers Program is an adaptation of the CORE program where the risk factors associated with sexual offending are addressed without participants needing to admit to the actual offending. The goal is to help each offender identify problems in his life that led him to be in a position where he could be accused of sexual offending and to develop strategies to prevent this from happening again. It is a 6 month program consisting of two sessions per week.

Self-Regulation Program

The self-regulation program for men who have sexually abused adults and/or children and who have an intellectual disability or other cognitive impairment and have limited adaptive skills in the gaol environment. It is offered to moderate and high risk/needs sexual offenders within a designated self-contained Additional Support Unit setting. It is a 12-18 month program with 3 sessions per week.

Maintenance Program

The maintenance program is an integral part of sexual offender treatment and management. It aims to assist participants to generalise skills, implement strategies developed in treatment and demonstrate behaviour change in a supportive environment. The aim of the program is to also strengthen self-management and release plans. The program is available to men who have completed a Sex Offender Treatment Program.

(b) Community Based Programs

To be eligible for a community based program the offender must:

- consent to undertake treatment
- be under the supervision of parole and probation
- have sufficient time remaining on their sentence to complete the treatment

program.
- have reasonable arrangements in place to ensure he could attend the location where the treatment group is held.
- acknowledge some level of responsibility for his sexual offence(s).

Forensic Psychology Services (FPS) treatment programs

FPS treatment is a community-based therapy program for men and women who have sexually abused adults and/or children. It provides treatment for moderate (moderate-low and moderate-high) risk sexual offenders and community-based maintenance programs for offenders who completed CUBIT/CORE in custody and are still under sentence. These programs are available for offenders who have not received a custodial sentence or for those who completed a custodial sentence but were unable to participate in a sex offender treatment program whilst incarcerated. It is a 6 - 12 month program with one session per week. FPS psychologists have an extensive involvement with each offender's parole officer and any other agency/service involved in his case management.

Regional treatment programs

A moderate (moderate low and moderate high) risk/needs community-based treatment program is available in the Northern region (Newcastle District Office) and South-West (Wollongong District Office) co-facilitated by the Sex Offender Programs Regional Supervisors and the cluster Community Offender Services (COS) senior psychologist.

High risk/high needs offenders

While CSNSW does not presently have an intensive treatment program for untreated high risk (high needs) offenders in the community, community-based CSNSW staff are able to provide risk management sessions to these offenders. These sessions may cover identification of risk factors, warning signs and a self-management plan. This does not address causal factors underlying the offending behaviour.

Community Maintenance Programs

These programs are provided for high risk sexual offenders who have successfully completed sex offender treatment in custody. It is usually a parole condition. Participants are expected to attend a session every week until they are no longer under the supervision of CSNSW. Offenders who are demonstrating a successful reintegration into the community are required to attend less frequently with some offenders only attending every four weeks. It allows offenders to further develop and implement their self-management plans and support networks in the community.

Offenders who have completed treatment programs in custody who live in remote and regional areas beyond the reach of FPS are provided with a rural after-care service either directly by the regional supervisor or by a COS psychologist under the

supervision of the regional supervisor. These services whilst beneficial are not deemed as equivalent to attendance at the formal maintenance program.

Research and evaluation

CSNSW has completed a number of research projects evaluating the effectiveness of CUBIT and CORE.

A risk band analysis was completed on 117 offenders who completed the CUBIT/CORE programs. These offenders had been in the community between 6 months and 6 years (average of 45 months). Only 8.5% of the 117 sexual offenders treated at CUBIT/CORE had been re-incarcerated for a sexual offence. The expected rate of recidivism of these offenders was 26% (based upon an established risk assessment instrument; Static-99, Hanson & Thornton, 1999). This equates to a 68% reduction in re-offending. A number of evaluations have demonstrated that the CUBIT treatment program has produced significant "within-treatment" changes. Sexual offenders who complete the CUBIT program:

- Show an increased use of effective coping strategies[12]
- Are less likely to engage in thinking which is supportive of offending[13]
- Show improvements in their ability to have close personal relationships and are less lonely.[14]

BOCSAR has also committed to a large evaluation of the CSNSW sex offender programs, due to commence in 2014. Community-based sex offender treatment programs will be included in this.

Custodial-based treatment programs

There is some evidence to suggest that rehabilitation that takes place within correctional facilities can be effective in reducing recidivism among sex offenders. A number of jurisdictions across Australia have undertaken evaluations of sex offender programs for prisoners, comparing rates of recidivism for treated prisoners with that of prisoners who were either untreated or who dropped out of rehabilitation programs.

An evaluation of the Victorian Sex Offender Program (SOP) reported a lower sexual offence recidivism rate for SOP completers (4%) than for non-completers who withdrew from the program (20%) and those who were removed from the program (10%).[15]

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[12] Feelgood, S. R., Golias, P., Bright, D., & Shaw, S. (2001, February). Treatment changes in the dynamic risk factor of coping style in sexual offenders. Paper presented at the Australian Psychological Society Forensic Psychology Conference.

[13] Mamone, N., Pervan, S., Sahm, K., & McElhone, M. (2002). A preliminary evaluation of the impact of an intensive treatment programme on the cognitive distortions of sexual offenders. Presented at the ANZATSA Biennial International Conference, Sydney, Australia.

[14] Kaw, A., Mamone, N., Pervan, S., & Sahm, K. (2002). Self-reported changes in intimacy and loneliness scores of treated sexual offenders with respect to their attachment style: An update. Paper presented at the Australia and New Zealand Association for the Treatment of Sexual Abusers, Second Biennial Conference, Sydney, Australia, April 2002.

A paper on the outcomes of the Queensland Corrective Services Sexual Treatment Programs reported rates of sexual recidivism (3%) to be half that for treated prisoners compared to non-treated prisoners (6%).[16]

Community-based treatment programs

Community-based rehabilitation can also be used in cases where it is considered safe for sex offenders to be in the general community.

There is some evidence that such treatment programs can reduce sex offender recidivism. A meta-analysis of 79 sex offender treatment studies that included almost 11,000 sex offenders found an overall recorded recidivism rate of 14.4% for treated child molesters compared to 25.8% for untreated controls.[17]

A recent outcome evaluation of three community child sex offender treatment programs in New Zealand examined differences in recidivism between 175 treated offenders and 28 controls who also had a history of child sexual offending found that the recorded sexual offence recidivism rate for offenders who had completed a program was 5.2%, with an overall rate of 8.1% for offenders who had participated in at least some of the program. Recidivism rates were thus higher for those who had dropped out of the program.[18]

Caution should be exercised in comparing results of community-based rehabilitation with custodial-based rehabilitation. Treatment programs for prisoners tend to focus on high-risk inmates, while community based programs often targeted lower risk offenders (who are able to be in the community). Recidivism in these studies is defined as reconviction.

Treatment programs for young offenders

Juvenile Justice runs a Sex Offender Program. It is available for young people convicted of a sex offence. The young person receives an individual functional analysis and an individualised counselling plan. The program is designed to reduce recidivism.

The New Street Adolescent Service program is run by NSW Health and provides a response to children and young people aged between 10-17 years who sexually abuse. For young people over the age of 10, this program is the only available option and there is substantial demand on the service with limited placements and resources.

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[15] Heseltine K, Sarre R, Day A, *Prison-based correctional rehabilitation: An overview of intensive interventions for moderate to high-risk offenders*, Trends & Issues in Crime and Criminal Justice no.412

[16] Smallbone, McHugh (2010), *Outcomes of Queensland Corrective Services Sexual Treatment Programs*, Griffith University

[17] Gelb K (2007), *Recidivism of Sex Offenders Research Paper*, Sentencing Advisory Council

[18] Lambie I, Stewart W (2003), *Community Solutions for the Community's Problem: An Outcome of the Evaluation of Three New Zealand Community Child Sex Offender Treatment Programs*

The use of anti-libidinal medication

There are a variety of medications that have an anti-libidinal effect. Those utilised in the management of sex offenders include Selective Serotonin Reuptake Inhibitors (SSRI's) medication and hormonal agents. The hormonal agents and the SSRI's have been shown in a variety of studies to reduce sexual interest, libido, sexual fantasies, urges and behaviours, arousal and sexual performance. Further information about anti-libidinal medication is included in Appendix A.

Scientific evidence on the effectiveness and efficacy of anti-libidinal medication in reducing recidivism is mixed.

Anti-libidinal medications form only part of any treatment approach and, as a risk management tool address only the sex drive component of the management. Other dynamic risk factors such as intoxication, dysphoric mood states, mental illness, anti-social associates, persistent attitudes that condone sexual offensive behaviours, opportunity, social isolation and social stressors can increase the risk despite anti-libidinal treatment. These are risk factors that would need to be managed in an ongoing treatment program.

The use of anti-libidinal medications in NSW

CSNSW refers sex offenders (includes individuals who have committed offences against adults and children) to Justice Health who assess their suitability for anti-libidinal medication. A team of Justice Health clinicians located within a CSNSW community-based sex offender program site was established in 2007 for the purpose of assessing and biologically treating sex offenders.

Currently referrals to Justice Health are made by CSNSW sex offender programs psychologists in custody and to the local gaol Justice Health clinic.

There is currently no state-wide CSNSW policy or procedure for referring an inmate to Justice Health for the purposes of assessing their suitability for anti-libidinal medication. Such referrals are generally made by psychologists working within CSNSW Sex Offender Programs (custody or community), using criteria developed in consultation with Justice Health. These criteria include:

- The offender has been assessed as high risk of sexual re-offending
- The offender is sexually preoccupied or has intrusive deviant fantasies and
- Where psychological treatment specific to the sexual deviance has not been successful.

All prescription of anti-libidinal medications is used to supplement psychological treatment (not as an alternative). The process of referral from CSNSW to Justice Health will differ depending on local gaol operations.

Currently, offenders in the community (including those on Extended Supervision Orders) who require anti-libidinal medication must consult their own GP who needs to find a forensic psychiatrist who specialises in anti-libidinal medication.

Comparisons between psychological and biological treatments

There is very little research that directly compares the psychological and biological treatment of sexual offenders.

The main reason for this is that it is inherently difficult to compare two methods of treatment when offenders invariably often receive both. Given that there is an absence of specific studies directly comparing biological and psychological treatment, it is necessary to examine larger scale meta-analyses, where a large number of studies are aggregated together in order to increase sample sizes so that treatment effects can be detected.

A meta-analysis of 12 treatment studies was conducted in 1995 which showed the most effective treatment programs were those that were either based on CBT or anti-libidinal medications. It was noted that whilst one third of participants dropped out of CBT programs, the drop-out rate for the anti-libidinal group was more than fifty percent.[19] In a separate large scale meta-analysis of sex offender treatment effectiveness reported that biological treatments had a much higher impact on recidivism rates than did psychological treatments, although they noted that the main source for the difference was a very strong effect of surgical castration.[20]

Hormonal treatments (CPA & MPA), however, were statistically more effective than psychological treatments, although in the larger scale meta-analysis it was noted that the studies using hormonal treatments often had psychological treatment as well. It was concluded that rather than being "better" than psychological treatments, hormonal treatments should be used to augment psychological treatment.[21]

There appears to be a consensus amongst researchers that for a small sample of high risk sexual offenders the use of medications for an anti-libidinal purpose (SSRIs, CPA, MPA) is likely to be an effective and important treatment approach when combined with CBT treatment.

In one study it was stated that "the weight of clinical evidence suggests that MPA [and CPA] has a temporary role to play in reducing risk in a select group of dangerous sex offenders if given intramuscularly (so that compliance can be ascertained)".[22] It was

[19] Hall GCN (1995). *Sexual recidivism revisited: A meta-analysis of recent treatment studies*, Journal of Consulting and Clinical Psychology; 63 (5); 802-809

[20] Lösel, F. & Schmucker, M. (2005). *The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis*. Journal of Experimental Criminology, 1, 117-146.

[21] Lösel, F. & Schmucker, M. (2005). T*he effectiveness of treatment for sexual offenders: A comprehensive meta-analysis*. Journal of Experimental Criminology, 1, 117-146.

[22] Maletzky, B. M., Tolan, A. & McFarland, B. (2006). *The Oregan Depo-Provera Program: A five year follow-up. Sexual Abuse*: A Journal of Research and Treatment, 18, pp400.

further noted that given the lack of controlled studies over sufficient durations with large enough numbers of subjects, the effectiveness of anti-libidinal medications cannot definitely be proven at this time.[23]

There is also consensus, however, that the strongest evidence for the use of medications with sex offenders comes from clinical studies and to a lesser extent the few available controlled studies.

Most researchers argue that further research is necessary particularly for SSRIs and LHRHs where research has been less extensive. On the basis of the available evidence, it appears sensible to include the option of anti-libidinal use in strategies relating to the treatment and management of high risk sex offenders particularly for the highest risk sexual offenders who pose an immediate risk.[24]

[23] Maletzky, B. M., Tolan, A. & McFarland, B. (2006). *The Oregan Depo-Provera Program: A five year follow-up. Sexual Abuse: A Journal of Research and Treatment,* 18,pp407.
[24] Harrison, K. (2007). *The high risk sex offender strategy in England and Wales: Is chemical castration an option?* The Howard Journal, 46, 16-31.

APPENDIX A: ANTI-LIBIDINAL MEDICATIONS

There are a variety of medications that have an anti-libidinal effect. These are categorised into the following broad classes of medications.

Seretonergic Medications - Selective Serotonin Reuptake Inhibitors (SSRI's)

Serotonin is a neurotransmitter found in the brain. The Selective Serotonin Reuptake Inhibitors (SSRI's) act to increase levels of the neurotransmitter serotonin (5-HT) and are usually used for a variety of psychiatric disorders, primarily those involving either mood or impulse control, including depression, generalised anxiety, obsessive compulsive disorders, and eating disorders. Medications with a serotonergic effect are known to, as a side effect, reduce sexual desire and delay ejaculation in men.[25]

It is unclear how SSRIs may reduce recidivism risk in sexual offenders however it could be as a result of:

(i) general inhibition of sexual activity;
(ii) reduction in impulsivity;
(iii) reduction in obsessive urges;
(iv) decrease in depressive symptoms;
(v) reduction in testosterone serum levels.[26]

SSRIs have been used in a number of uncontrolled studies to treat exhibitionists, fetishists, voyeurs, and child molesters with favourable results. Reductions in fantasies, sexual urges, masturbation, and paraphillic behaviours have been reported in as little as two to four weeks after commencement of treatment.[27]

A review of the clinical effectiveness and cost-consequences of selective serotonin reuptake inhibitors in the treatment of sex offenders was undertaken which examined the nine studies that existed – all of which were from the United States. The total number of subjects across all nine studies was only 225.

Although reporting an overall positive result, it was concluded that the evidence for the effectiveness of SSRIs with sexual offenders, while appearing positive, is far from conclusive. It was noted significant methodological limitations with each of the nine studies and recommended that further research be undertaken. Further, there

[25] Greenberg, D. M. & Bradford, J. M. W. (1997), *Treatment of the paraphilic disorders: a review of the role of the selective serotonin reuptake inhibitors*. Sexual Abuse: A Journal of Research and Treatment, 9, 349–360.
[26] Briken, P., Hill, A., & Berner, W. (2003). *Pharmacotherapy of paraphillias with long-acting agonists of luteinising hormone-releasing hormone: A systematic review*. Journal of Clinical Psychiatry, 64, 890-897
[27] Bourget D., and Bradford, J, (2008), *Evidential basis for the assessment and treatment of sex offenders.* Brief Treatment and Crisis Intervention, 8:1, February 2008, Oxford University Press.

were a number of negative outcomes where SSRIs did not reduce sexual drive in sex offenders.[28]

These limitations notwithstanding, in comparison with other classes of medications used with sexual offenders, it was noted that SSRIs have the following advantages:

(i) They are familiar to most psychiatrists and therefore do not necessarily require the expertise required when prescribing anti libidinal medication;
(ii) There are fewer side effects which are, in general, less serious;
(iii) SSRIs are likely to be more attractive to sexual offenders than anti-libidinal medications.

Hormonal Agents

Testosterone is the most important hormone that modulates sexual behaviour. There is also some evidence that testosterone modulates serotonin[29]

There are three types of Hormonal Agents, which have been used in the management of sex offenders. There is a relationship between the reduction of testosterone and its effects and the reduction in sex drive. These include Cyproterone Acetate (CPA)-Androcur , Medroxyprogesterone Acetate (MPA)-Depot Provera, and Luteinizing Hormone Releasing Hormone Agonists (LHRH agonists).

CPA and MPA are the medications most commonly associated with the anti-libidinal treatment of sexual offenders. CPA and MPA act at different points in hormonal function to reduce circulating testosterone by either increasing its metabolism in the liver (MPA) or by blocking cellular adhesion of normal circulating testosterone (CPA).

Both CPA and MPA ultimately reduce testosterone levels. Within a few days of commencing treatment testosterone levels are significantly reduced, although the full effects on libidinal functioning are not apparent for a further four to eight weeks.[30] It is important to note that CPA and MPA do not seem to work by reducing extremely high levels of testosterone. There is no evidence that sex offenders have abnormally high levels of testosterone.[31] Rather CPA and MPA work by reducing more or less normal levels of testosterone and sexual arousal.[32]

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[28] Adi, Y., Ashcroft, D., Browne, K., Beech, A., Fry-Smith, A., & Hyde, C. (2002). *Clinical effectiveness and cost-consequences of selective serotonin reuptake inhibitors in the treatment of sex offenders* (Health Technology Assessment, 6, No. 28). London: Her Majesty's Stationary Office

[29] Briken, P., Hill, A., & Berner, W. (2003). *Pharmacotherapy of paraphillias with long-acting agonists of luteinising hormone-releasing hormone: A systematic review*. Journal of Clinical Psychiatry, 64, 890-897.

[30] Harrison, K. (2007). *The high risk sex offender strategy in England and Wales: Is chemical castration an option?* The Howard Journal, 46, 16-31

[31] Fedoroff, J. P., & Moran, B. (1997).*Myths and misconceptions about sex offenders*. Canadian Journal of Human Sexuality, 6, 263-276.

[32] Rosler, A. & Witztum, E. (2000) *Pharmacotherapy of paraphilias in the next millennium*. Behavioral Sciences and the Law, 18, 43–56.

Both CPA and MPA have a number of potentially serious side effects including a number that are labelled as potentially life threatening or which pose serious threats to health.[33] Many of these side effects are dose dependent. Some research indicates very few patients would suffer from severe side effects, although slight breast development in males can occur in up to 20% of cases where CPA is used. [34] CPA reportedly has fewer side effects than MPA.[35]

Use and effectiveness of CPA - Androcur

CPA is primarily used in Europe and Canada. The United States Food and Drug Administration (FDA) does not approve the use of CPA because of the risk of liver toxicity.[36]

CPA is a synthetic steroid structurally similar to progesterone - a steroid hormone involved in the female menstrual cycle, pregnancy, and embryogenesis of humans and other species. CPA acts mainly by blocking testosterone receptors resulting in reduced serum levels of testosterone, inhibition of the production of sperm, and decreased ejaculate volume. CPA may take only two to four days to produce significant effects.

There is very little evidence as to CPA's effectiveness and that which exists has methodological limitations. There appears to be four case reports, eight case studies, three double-blind placebo-controlled studies, and one double-blind comparison study that evaluated sex offenders treated with CPA. These studies totalled over 260 subjects. The majority of these studies were completed from the 1970s to early 1990s.

The overall results of these studies appear promising yet they are limited by methodological weaknesses. The use of CPA had positive effects within the case studies. The intensity and frequency of paraphillic fantasies and behaviours, testosterone levels, sexual drive, and a reduction in penile tumescence in response to evocative stimuli have all been indicated.[37]

The results of the double-blind, placebo controlled studies and the double-blind comparison, were mixed. Only one study showed statistically significant differences,

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[33] Glaser, B. (2003). *Integrating pharmacological treatments*. In T Ward, D. R. Laws, & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp262-279). Ondon: Sage Publications, Inc.
[34] Maletzky, B.M., & Field, G. (2003). *'The Biological Treatment of Dangerous Sexual Offenders: A Review and Preliminary Report of the Oregon pilot depo-Provera program*', Aggression and Violent Behavior, 8, 397.
[35] Harrison, K. (2007). *The high risk sex offender strategy in England and Wales: Is chemical castration an option?* The Howard Journal, 46, 16-31
[36] Maletzky, B. M. (1998). *The paraphilias: Research and treatment*. In P. E. Nathan & J. M. Gorman (Eds.), A guide to treatments that work (pp 472-500). Oxford: Oxford University Press.
[37] Nelson, E. B., Soullo, C. A., Delbello, M. P., & McElroy, S. L. (2002). *The psychopharmacological treatment of sex offenders*. In B. K. Schwartz (ed.), The sex offender: Current treatment modailities and systems issues (pp 13-1 - 13-23). Kingston, New Jersry: Civic Research institute.

although this is probably due to the small sample sizes used in most studies. Statistical significance is numerically more difficult to obtain with small sample sizes.

One study for example, used a double-blind crossover trial, reporting that in 19 offenders, CPA, but not placebo, significantly reduced self-reported sexual arousal to visual sexual stimuli.[38] This was replicated in a second study with a further 17 offenders, although in this case the plethysmograph was used.

Use and effectiveness of MPA – Depo-Povera or Provera

MPA is a long-acting female contraceptive that is primarily used and has been studied in the United States and to a lesser extent Canada. The use of MPA is approved in the United States, although not as a treatment of paraphilias. It is therefore used "off label" in the USA.

When used with sexual offenders, oral administration of MPS usually takes 10-14 days by which point the offender will have a below 'normal' level of testosterone in his body. This, in turn, affects sexual arousal, penile circumference, and sexual fantasies/urges but will "probably" not affect erection capabilities. Offenders, therefore, could in theory perform sexually with appropriate adult partners, although there is likely to be less desire to do so.

The reduced testosterone levels result in sex drive being reduced or inhibited and orgasm, potency and sperm production are all affected. There are also reduced sexual thoughts and fantasies, frequency and pleasure of masturbation and lowered sexual frustration.[39]

Again, there is a surprisingly small amount of evidence relating to MPA's effectiveness, particularly given that MPA is used as part of mandated treatment in nine states in North America. One summary of existing literature found 13 case reports, 12 case studies, and 5 placebo-controlled studies that evaluated sex offenders treated with MPA. These studies totalled just over 300 subjects.[40]

The overall results of these studies are promising yet limited by methodological weaknesses. The case reports and studies demonstrated reductions in sexual fantasies and arousal, paraphillic behaviours, sexual recidivism, and relapse rates with MPA given both orally and intramuscularly. These positive results have only partially been supported by placebo controlled studies.

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[38] Bradford, J. M. W., & Pawlak, M. A. (1993). *Double-blind placebo cross-over study of cyproterone acetate in the treatment of the paraphilias*. Achives of Sexual Behaviour, 22, 383-402.

[39] Greenberg, D. M. & Bradford, J. M. W. (1997), *Treatment of the paraphilic disorders: a review of the role of the selective serotonin reuptake inhibitors*. Sexual Abuse: A Journal of Research and Treatment, 9, 349–360.

[40] Nelson, E. B., Soullo, C. A., Delbello, M. P., & McElroy, S. L. (2002). *The psychopharmacological treatment of sex offenders*. In B. K. Schwartz (ed.), The sex offender: Current treatment modailities and systems issues (pp 13-1 - 13-23). Kingston, New Jersry: Civic Research institute.

Four of the five placebo-controlled studies showed decreases in offender self-reporting of symptoms, but only one of these studies used more objective measures (i.e., plethysmograph). One study found that five of eight "hard core" sex offenders who were administered MPA reported reductions in deviant sexual fantasies however this was not substantiated by measurements in the offender's responses to stimuli presented by plethysmograph.[41] This raises the possibility that sex offenders are simply reporting that the medications are effective, when they may not be, or not to the extent that an offender is reporting.

The largest study compared 79 sexual offenders who received depo-provera with 55 offenders who did not receive it (even though it was recommended for them) over a follow up period of up to 4 years. The study found that offenders receiving depo-provera committed no new sex offences and fewer non-sexual offences. Almost one third of offenders judged to need medication but did not receive it committed further sexual offences. Of note, these all appeared to be high risk sex offenders.[42] In two separate studies it has been reported that termination of MPA may rapidly increase relapse rates and the risk of sexual recidivism.[43]

Use and effectiveness of LHRH or GNRH Agonists

Chronic administration of LHRHs have the effect of stimulating the pituitary gland to dramatically increase the production of hormones, causing a rapid rise in testosterone levels, so that an exhaustion occurs followed by a rapid reduction in testicular secretion of testosterone to castration levels. LHRHs are ineffective orally and are administered by depot injections.[44]

The effectiveness of LHRHs has been examined in at least 6 case studies, one case control study, and seven open uncontrolled studies.[45] All of these 13 studies have significant methodological limitations.[46] The total number of subjects was 118, although only 43 of these men were diagnosed with paraphilia, whereas the deviant sexual interests of the others were unclear. All of these studies reported significant decreases in sexually deviant behaviours and fantasies or interests as measured by client self-report.

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[41] Kiersch, T. A. (1990). *Treatment of sex offenders with depo-provera*. Bulletin of the American Academy of Psychiatry and Law, 18, 179-187

[42] Maletzky, B. M., Tolan, A. & McFarland, B. (2006). *The Oregan Depo-Provera Program: A five year follow-up. Sexual Abuse*: A Journal of Research and Treatment, 18,

[43] Berlin, F.S & Meinche, C.F (1981), *Treatment of sex offenders with antiandrogenic medication: Conceptualisation, review, treatment modalities and preliminary findings*, American Journal of Psychiatry, 138, 601-607

[44] Glaser, B. (2003). *Integrating pharmacological treatments*. In T Ward, D. R. Laws, & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp262-279). Ondon: Sage Publications, Inc

[45] Briken, P., Hill, A., & Berner, W. (2003). *Pharmacotherapy of paraphillias with long-acting agonists of luteinising hormone-releasing hormone: A systematic review.* Journal of Clinical Psychiatry, 64, 890-897

[46] Nelson, E. B., Soullo, C. A., Delbello, M. P., & McElroy, S. L. (2002). *The psychopharmacological treatment of sex offenders*. In B. K. Schwartz (ed.), *The sex offender: Current treatment modailities and systems issues* (pp 13-1 - 13-23). Kingston, New Jersry: Civic Research institute

The largest study evaluating the use of a LHRH was with a total of 36 men with paraphillias who were medicated for between eight to 42 months. It was reported a complete reduction of paraphillia acts and significant decreases in measures of sexual interest, activity, and fantasies.[47] Of note, LHRH has been reported to be successful when CPA or MPA was not.[48] It has been noted that although LHRHs appear to have a more potent impact on testosterone levels and sexual arousal than CPA or MPA and its side effect profile appears to be milder. However, osteoporosis (thinning of bones) is a particular problem. The LHRH medications are also significantly more expensive.[49]

Given the lack of controlled studies, possible serious side effects, and expensiveness of LHRHs, some researchers label their use as “experimental at present”.[50]

Issues relating to the prescription and administration of anti-libidinal medication

All of these medications have effects on plasma testosterone by reducing its effect and availability and thus reducing sexual drive, arousal and performance. The combination of hormonal agents and SSRI's allows for a lower dose of hormonal agents and thus reduces the risk for side effects.

Intramuscular hormonal agents (injections) have advantage over oral agents in that intramuscular delivery ensures that the person attends for appointments and that the medication has been taken. Oral hormonal agents are less reliable but regular hormonal blood testing can monitor compliance. Oral agents have advantages because they allow for finer adjustments in dose.

Given the limited scientific support for the effectiveness of these medications, informed consent is required for their prescription, which should include an explanation of their "experimental" status in the treatment of sex offenders.

Medication should ideally be prescribed in conjunction with psychological treatment. The psychological treatments would generally involve either individual or group therapy, most commonly utilising a cognitive behavioural approach (cognitive behavioural therapy attempts to address justifications that lead to offending behaviour and attitudes towards offending).

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[47] Rosler, A., & Witzum, E. (1998). *Treatment of men with paraphilia with a long-acting analogue of gonadotropin-releasing hormone*. New England Journal of Medicine, 338, 416-422

[48] Bradford, J.M.W. (2000). *The treatment of sexual deviation using a pharmacological approach*. Journal of Sex Research, 3, 248-257; Dickey, R. (1992) *The management of a case of treatment-resistant paraphilia with a long-acting LHRH agonist*. Canadian Journal of Psychiatry, 37, 567–569

[49] Grubin, D. (2008). *Medical models and interventions in sexual deviance*. In D. R. Laws & W. T. O'Donohue (Eds.), *Sexual deviance: Theory, Assessment, and treatment* (2nd addition) (pp594-610). New York: Guildford Press

[50] Glaser, B. (2003). *Integrating pharmacological treatments*. In T Ward, D. R. Laws, & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp262-279). Ondon: Sage Publications, Inc.pp271

Relapse prevention is also a treatment approach that promotes self-management and self-regulation by providing the offender with strategies and skills to pursue a more productive life style and to avoid high-risk situations. It forms the basis of most sex offender treatment programs.

Issues relating to monitoring the effects of anti-libidinal medication

As with any medication, the risk for side effects remains as long as the individual is exposed to the medication. Some side effects can be serious and patients require ongoing assessment and management.

The prescriptions of these agents should always be preceded by a baseline assessment, which should include standard psychiatric evaluation with specific emphasis on the person's psychosexual history and current psychosexual state; physical examination; bloods for hormonal and metabolic profile; and ECG and bone scan. Facilities for ongoing monitoring for side effects, changes in hormonal profile and bone scans should be available for the duration of the treatment. A clinician with experience with both anti-libidinal medications and sex offenders, and not only one or the other, should ideally prescribe the treatment.

The initial phase of treatment with either SSRI's or hormonal agents generally requires more intense monitoring, which allows for a therapeutic alliance and evaluation of the suitability of the medication. Frequency of contact with the prescribing clinician will be determined by side effects, level of response, adherence, and perceived risk of relapse. Monitoring of side effects is important and this might require the inclusion of a general practitioner and sometimes an endocrinologist.

Hormonal treatments require more intense medical monitoring than SSRI's because of their side effect profile and because part of monitoring their efficacy involves monitoring hormonal levels. Overall regular monitoring of metabolic status and liver function tests and physical examination should occur at least every six months, with a bone-scan every year. Monitoring of blood hormone levels should be more frequent as this allows the opportunity to monitor compliance if the person is taking the hormone agents orally.

MPA and CPA could be contraindicated in individuals with liver disease, those with cardiovascular disease, a history of a stroke or another thrombo-embolic (clots) episodes, long-term diabetes, kidney disease, breast cancer and migraines.

The goal of hormonal agents is to reduce plasma testosterone. There is no common standard testosterone plasma level below which a change in sex drive is achieved. Each individual should be managed according to his own baseline levels and medications adjusted accordingly. There is also not necessarily a relationship

between the degree of reduction in testosterone and degree of reduction in sexual interest and drive.

Suitability of offenders for use of anti-libidinal medications

If anti-libidinal medications are to be used, then the establishment of clear practice guidelines is critical as the use of anti-libidinal medications is not indicated for all sexual offenders.

From a very broad perspective the following can be indications that an assessment of suitability for anti-libidinal medications *may* be necessary.

1. Sexual history reveals high rates of deviant acts that are persistently evident over an extended period of time.
2. Phallometric assessments indicate either strong deviant sexual arousal or very high sexual arousal to all stimuli (i.e., normative and deviant).
3. The offender self-reports either excessive masturbation (e.g., more than once per day) or persistent, intrusive, deviant sexual fantasies, or persistent arousal to staff or to persons depicted in the media.
4. The offender's institutional behaviour reveals he is collecting pornography or watching television shows that depict person's matching his victims (e.g., children's shows or shows portraying violence against women) and he persists in these activities despite advice to desist.
5. The offender's institutional behaviour reveals either persistent attempts to engage staff in romantic or sexualized behaviour that is not discouraged by feedback, or incidents of sexual assaults or sexual harassment of staff or other inmates.
6. Hormonal assay reveals abnormally high levels of testosterone.[51]

There is almost universal agreement that anti-libidinal medications should only be administered in conjunction with psychological treatment.[52]

Some research states that anti-libidinal medications should only be used when cognitive behaviour techniques used to assist an offender to manage deviant sexual fantasies or arousal have been trialled and have been unsuccessful. In addition, anti-libidinal medication should only ever be used as a *temporary* control, for those

[51] Marshall, W. L., Marshall, L. E., Serran, G. A., & Fernandez, Y. M. (2006). *Treating sexual offenders: An integrated approach*. New York: Taylor & Francis Group.
[52] Association for the Treatment of Sexual Abusers (ATSA); Grubin, D. (2000). *Complementing relapse prevention with medical intervention*. In D. R. Laws, S. M. Hudson, & T Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp 201-212). London: Sage Publications, Inc.; Glaser, B. (2003). *Integrating pharmacological treatments*. In T Ward, D. R. Laws, & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp262-279). Ondon: Sage Publications, Inc

offenders whose sexual drive is excessively high, in order to allow the offender to develop and use psychological strategies.[53]

Anti-libidinal medications may also be used to complement psychological treatment. Their use will not only suppress sexual urges and desires, but will also assist the individual's ability to concentrate and benefit from psychological treatments.

The following treatment algorithm can be used to assist in the use of anti-libidinal medications. This reflects both the need for psychological treatment and the ethical notion that the least adverse treatment options must be considered first.

- Level 1. Psychological treatment only
- Level 2. Psychological treatment and use of SSRIs
- Level 3. Psychological treatment and small dose of hormonal agent if SSRIs not effective
- Level 4. Psychological treatment and full use of hormonal agent given orally
- Level 5. Psychological treatment and full use of hormonal agent given intramuscularly.
- Level 6. Psychological treatment and full use of hormonal agent given intramuscularly at highest dosage.[54]

Practice guidelines serve the purpose of informing and guiding best practice principles in the referral, application, and monitoring of anti-libidinal treatments.

The Association for the Treatment of Sexual Abusers (ATSA) is an international organisation focused specifically on the prevention of sexual abuse through effective management of sex offenders. ATSA was founded to foster research, facilitate information exchange, further professional education and provide for the advancement of professional standards and practices in the field of sex offender evaluation and treatment.

ATSA's position paper dedicated to the use of anti-libidinal medications states:

- The role of sexual motivation varies among abusers; therefore, the reduction of sexual drive would be of limited usefulness for some abusers.
- Not all abusers are the same and anti-androgen therapy is not appropriate for use with all sexual abusers. It is important to develop ordered and reasonable criteria based on diagnosis, history, motivation and risk when prescribing the medical intervention.

[53] Marshall, W. L., Marshall, L. E., Serran, G. A., & Fernandez, Y. M. (2006). *Treating sexual offenders: An integrated approach*. New York: Taylor & Francis Group.
[54] Bradford, J.M.W. (2000), *The treatment of sexual deviation using a pharmacological approach*. Journal of Sex Research, 3, 248-257

- The effect of surgical castration is to reduce the availability of androgen by removing the testes where approximately 95% of the testosterone is produced. Although it seems reasonable and has, in fact, been shown that surgical castration may reduce paraphiliac fantasies and behaviours, there are alternative and less invasive treatments available.
- A substantial percentage of surgical castrates retain sexual functioning. Even if an abuser's capacity to have an erection or ejaculate is permanently inhibited, the act of sexual aggression many times involves more than the use of the penis and those behaviours would not be affected

ATSA further states that adult offenders that could be considered for these medications include sexual offenders assessed as high risk of sexually re-offending, who may exhibit predatory violent or sadistic sexual behaviour, or who may have experienced multiple treatment failures, and report persistent and compulsive fantasies (deviant sexual interests) with a proven inability to control their arousal.

ATSA indicates that anti-libidinal medications should only be used in combination with psychological treatments. This is because reducing sexual arousal will not necessarily reduce the motivation to commit sexual offences.

The Australia and New Zealand Association for the Treatment of Sexual Abusers (ANZTSA) does not mention anti-libidinal medications or their use within its code of conduct and ethics.

However, there are practice guidelines available in Victoria (*Interim Guidelines for Anti-libidinal Treatment*, Justice Health, 2008) and in New South Wales (*NSW Sex Offenders: Paper on Anti-libidinal Therapy Guidelines, September*, 2006, NSW Justice Health and NSW Department of Corrective Services). The content of both of these guidelines appear to be consistent with those outlined by ATSA.

Victoria's interim guidelines for anti-libidinal treatment state that use is appropriate for a "small cohort of high risk, high deviance, repeat sex offenders that have not responded to conventional therapeutic programs and other medication types, or have been assessed as unlikely to achieve therapeutic gains due to high levels of arousibility and intrusive deviant fantasy".[55]

The NSW paper also states that the use of anti-libidinal medications are for a "targeted" group of sex offenders.

Both the Victorian guidelines and NSW paper state that this form of treatment is only to be used as part of an "integrated" or "combined" treatment plan.

[55] *Interim guidelines for anti-libidinal treatment* , Victoria Justice Health, 2009, pp5

The evidence for and against the use of these medications

Any conclusions as to the effectiveness of anti-libidinal medications are limited by the following significant methodological problems inherent in the majority of the studies as to their effectiveness:

1. It is likely that only positive case reports have been published and negative outcomes are rarely described.
2. All of these studies had very small sample sizes, sometimes as few as 10 men or less.
3. Upon review, the samples have been very heterogeneous. As an example, some included exhibitionists, child molesters, and others who had reported deviant sexual paraphilias. It is unclear from the studies, but it is possible that these men may actually have been assessed a low risk of sexual recidivism.
4. There is a lack of randomised controlled trials. The result of this is potential selection biases, i.e., study participants were motivated to take medication.
5. Almost all of these studies had a limited follow up period – often less than 12 months. Within the psychological treatment outcome studies literature a period of 5 years is considered necessary.[56]
6. Most of the studies have relied upon self-report as the sole measures of reduction in deviant sexual interests.[57]
7. Even when physiological levels of serum testosterone are objectively measured, there is only a limited correction with sexual arousal and the levels required to achieve erection vary between individuals.[58]
8. Very few studies have actually used sexual recidivism to measure anti-libidinal effectiveness.[59]
9. There are frequently high drop-out rates reported, often as a result of side effects.
10. Unless taking intramuscularly, non-compliance with medications limits the effectiveness of both MPA and CPA.[60]
11. Many of these studies included offenders, or individuals, who were also receiving psychological treatment, and other interventions.

[56] Ware J & Bright D.A, 2008, *Evolution of a treatment programme for sex offenders: Changes to the NSW Custody-Based Intensive Treatment (CUBIT)*, Psychiatry, Psychology and Law, 15(2), 340-349.
[57] Adi, Y., Ashcroft, D., Browne, K., Beech, A., Fry-Smith, A., & Hyde, C. (2002). *Clinical effectiveness and cost-consequences of selective serotonin reuptake inhibitors in the treatment of sex offenders* (Health Technology Assessment, 6, No. 28). London: Her Majesty's Stationary Office.
[58] Glaser, B. (2003). *Integrating pharmacological treatments*. In T Ward, D. R. Laws, & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp262-279). Ondon: Sage Publications, Inc
[59] Glaser, B. (2003). *Integrating pharmacological treatments*. In T Ward, D. R. Laws, & S. M. Hudson (Eds.), Sexual deviance: Issues and controversies (pp262-279). Ondon: Sage Publications, Inc
[60] Maletzky, B.M., & Field, G. (2003). *'The Biological Treatment of Dangerous Sexual Offenders: A Review and Preliminary Report of the Oregon pilot depo-Provera program', Aggression and Violent Behavior*, 8, 391-412.

Use of anti-libidinal medication in other jurisdictions

Australia and New Zealand

Only CPA is currently sanctioned by the Australian Therapeutic Goods Administration (TGA) for the explicit purpose of reducing sexually deviant behaviours. As per the Schedule of Pharmaceutical Benefits (SPB; effective 1 March 2009), only CPA (Androcur) is subsidised by the Australian Government.

It is important to note that although MPA and LHRH are not included on the SPB, they can be used in Australia "off license" (this is called "off-label" in the USA) if a request is made by the assessing or treating psychiatrist to use a drug for a purpose other than what it is sanctioned for.

It is unclear how many sexual offenders have been prescribed SSRIs, CPA, or MPA for the purpose of reducing their risk of sexual recidivism within Australia and New Zealand. No jurisdiction could provide numbers as to how many sex offenders were currently being prescribed anti-libidinal medications.

It appears that anti-libidinal medications are very rarely used in New Zealand, and Northern Territory. They appear to be used more frequently, however still in a limited fashion in Victoria, Queensland, and NSW. It is unclear whether they are used within ACT, South Australia, and Tasmania.

United States

A large scale survey of 951 North American treatment programs has been conducted which reviewed surveys from 2000 and 2002 and reported that medication use with sexual offenders appeared to be *decreasing*.[61] In 2002, 52.1% of residential treatment programs for adult sexual offenders used one or more of Lupron (LHRH agonist), SSRIs, or Provera (MPA).

Of these programs, 45.2% used SSRIs, 30.1% used Provera, 21.5% used Lupron, and 7.5% used another medication type. This does not mean that every sexual offender within the program was medicated, but rather that the program used these medications for certain offenders.

In 2000, 78% of residential treatment programs for adult sexual offenders in North America reported using SSRIs, whereas this figure had dropped to 45% by 2002. This may have been attributable to funding decreases over this period however there was, an increase in the use of Lupron (LHRH agonist) from 14% to 22%.

[61] McGrath, R. J., Cumming, G.F., & Burchard, B.L. (2003). *Current practices and trends in sexual abuser management: Safer Society 2002 nationwide survey*. Brandon, VT: Safer Society Press.