

# Position Paper

## The Management and Treatment of Child Sex Offenders



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# About Bravehearts Inc.

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Founded in 1997 by Hetty Johnston, Bravehearts Inc. has evolved into an organisation whose purpose is to provide therapeutic, support and advocacy services to survivors of child sexual assault. We are also actively involved in education, prevention, early intervention and research programs relating to child sexual assault.

Bravehearts operates from our Head Office on the Gold Coast, advocating and lobbying nationally, with branches across the country.

The work of Bravehearts in the community includes:

- **The Ditto® Suite of Programs:** Includes *Ditto's Keep Safe Adventure* - CD ROM and Ditto's in-school protective behaviours education program.
- **Research:** Bravehearts is actively involved in research and policy development that prevents, responds to and ultimately reduces the incidence of child sexual assault.
- **Lobbying and Campaigning:** Bravehearts advocates for survivors directly and more broadly, through participation in State and Commonwealth government committees, inquiries and working parties, media, community debate and legislative review and reform.
- **Bravehearts Online:** Our online partnerships with Google and YouTube, together with our presence on other social networking sites such as Facebook, provides for the sharing of information, advice and support directly to young people and those who care for them.
- **Practitioner Workshops:** Bravehearts provides a suite of workshops tailored to provide specialist professional development education to therapists.
- **Supporting Hands:** This program provides valuable and effective training and awareness workshops on risk management for staff and volunteers in organisations that have contact with children, including teachers.
- **Community Awareness Campaigns:** Now partially funded by the Commonwealth Government, National White Balloon Day® is our signature awareness campaign. Held annually since 1997 in September during Child Protection Week Visit: [www.whiteballoonday.com.au](http://www.whiteballoonday.com.au)
- **Risk Audit:** Bravehearts provides a specialised Physical and Policy Risk Management Audit service for community groups, sporting clubs, retail and commercial sites that engage with children.
- **Counselling and Support Programs:** We provide counselling and support to children, adolescents and adult survivors of child sexual assault, as well as their family members.
- **Sexual Assault Disclosure Scheme:** SADS successfully encourages survivors to overcome the barriers to disclosure and as such, protects thousands of children from those who, through SADS, become known predators.
- **Telephone Crisis and Advocacy:** Bravehearts currently provides a Freecall 1800 BRAVE 1 (1800 272 831) crisis-support and advocacy line. We receive more than 80 phone calls each week from people who need timely accurate advice, assistance or referral in times of crisis.

# Abstract

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In Australia, most paedophiles (more than 90 percent) escape the notice of the authorities (Queensland Crime Commission and Queensland Police Service, 2000). Of those that are actually convicted, only a proportion are treated and managed in a way that is likely to reduce the incidence of their re-offending.

There are several sentencing options for convicted paedophiles. Some paedophiles receive prison sentences, perhaps with the requirement to participate in a therapy intervention while in prison. Non-prison sentences include: periodic detention, community service (which often does not involve supervision or access to a treatment program), supervised recognisance (which includes supervision of the offender for up to 3 years), unsupervised recognisance or a fine. In 1992 only 48 percent of those convicted of sexual assaults on children went to prison (cited in NSW Child Protection Council, 1996).

A prison sentence by itself is an ineffective deterrent to re-offending for paedophiles, except while they are in prison. However, there are various treatment interventions and management strategies that are being used in an attempt to achieve this end. The objective of this Position Paper is to summarise the information available on these interventions, and to report on their varying degrees of success. The paper also presents Bravehearts' own Position Statements on the treatment and management of paedophiles.

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# Background Literature and Research

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## **The needs for effective intervention**

Individuals who sexually offend against children are an extremely diverse group, and it is not possible to describe the “typical” child molester. They differ in terms of their choice of victim, their criminal backgrounds, their sexual arousal patterns, their social functioning, and their risk of re-offending. Although this list can be lengthened endlessly, it is these features that figure most prominently in the literature.

The criminal justice system manages most convicted sex offenders with some combination of incarceration, community supervision, and specialized treatment; the majority are released at some point on probation or parole (either following sentencing or after a period of incarceration in prison or jail).

Of the many factors that underscore the critical importance of effectively managing sex offenders on probation, parole, or under other forms of community supervision, none is more compelling than the devastating trauma visited on victims of sexual assault.

Components of the trauma associated with sexual assault include shame, self-blame, fear, developmental crises, posttraumatic stress disorder, and the threat or actuality of physical violence, terror, and injury. Most profound in its traumatic implications is the violation of trust that occurs if, as in most sexual assault victimisations, offenders are known to victims. Trauma and the length and level of recovery seem linked to trust violation more than to many other factors. Thus, what might be regarded by some as a relatively minor type of sexual assault (e.g., “just fondling”) can be extremely traumatic to a victim who trusted the perpetrator.

The accelerating influx of sex offenders into the criminal justice system further heightens the need for effective sex offender supervision and management practices, both in and out of prisons.

Treatment for sex offenders typically includes “A cognitive behavioral approach, which emphasizes changing patterns of thinking related to sexual offending and changing deviant patterns of arousal; ...a psycho-educational approach, which stresses increasing the offenders concept of the victim and recognition of responsibility for their offense; and the pharmacological approach, which is based upon the use of medication to reduce arousal” (Center for Sex Offender Management, 2001a). According to the Harvard Mental Health letter, anti-androgen medications are “the only reliable way, proven in controlled studies, to suppress paedophilic urges.”

There is a generally held perception that sex offenders are untreatable

## How do we achieve effective intervention?

***The heterogeneity of sex offenders must be acknowledged.*** Although sex offenders are often referred to as a "type" of offender, there are a wide variety of behaviours and offender backgrounds that fall into this classification of criminals (Knight and Prentky, 1990). As mentioned earlier, many sex offenders have histories of assaulting across sex and age groups—recent research (Ahlmeyer, Heil, McKee, and English, 2000) found that these offenders may be even more heterogeneous than previously believed.

***Criminal justice professionals must continue to expand their understanding of how sex offenders are different from the general criminal population.*** Although some sex offenders are unique from the general criminal population (e.g., many extrafamilial child molesters), others (e.g., many rapists) possess many of the same characteristics that are associated with recidivism of general criminal behaviour. As criminal justice understanding of these offenders and the factors associated with their behaviour increases, more refined classification needs to be developed and treatment programs need to be redesigned to accommodate these differences.

***Interventions should be based on the growing body of knowledge about sex offender and general criminal recidivism.*** Research demonstrates that while sex offenders are much more likely to commit subsequent sexual offences than the general criminal population, they do not exclusively commit sexual offences. Therefore, some aspects of intervention with the general criminal population may have implications for effective management of sex offenders. Quinsey (1998) has recommended that in the absence of definitive knowledge about effective sex offender treatment, the best approach would be to structure interventions around what is known about the treatment of offenders in general.

In the realm of interventions with general criminal offenders, there is a growing body of literature that suggests that the cognitive-behavioural approach holds considerable promise (Gendreau and Andrews, 1990). Cognitive-behavioural treatment involves a comprehensive, structured approach based on sexual learning theory using cognitive restructuring methods and behavioural techniques. Behavioural methods are primarily directed at reducing arousal and increasing pro-social skills. The cognitive behavioural approach employs peer groups and educational classes, and uses a variety of counselling theories. This approach suggests that interventions are most effective when they address the criminogenic needs of high-risk offenders (Andrews, 1982). The characteristics of programs that are more likely to be effective with this population include skill-based training, modelling of pro-social behaviors and attitudes, a directive but non-punitive orientation, a focus on modification of precursors to criminal behaviour, and a supervised community component (Quinsey, 1998).

Although these program characteristics may be instructive in forming the basis for interventions with sex offenders, treatment approaches must incorporate what is known about this particular group of offenders. A number of characteristics that are typically associated with the recidivism of sex offenders were identified in this

document, including: victim age, gender, and relationship to the offender; impulsive, antisocial behaviour; the seriousness of the offence; and the number of previous sex offences. Also, an influential factor in sex offender recidivism is the nature of the offender's sexual preferences and sexually deviant interests. The discovery and measurement of these interests can serve as a focus for treatment intervention.

***Dynamic factors should influence individualized interventions.*** In addition, dynamic factors associated with recidivism should inform the structure of treatment and supervision, as these are characteristics that can be altered. These factors include the formation of positive relationships with peers, stable employment, avoidance of alcohol and drugs, prevention of depression, reduction of deviant sexual arousal, and increase in appropriate sexual preferences, when they exist.

Interventions that strive to facilitate development of positive dynamic factors in sex offenders are consistent with cognitive-behavioural or social learning approaches to treatment. Such approaches determine interventions based upon an individualized planning process, utilizing standard assessment instruments to determine an appropriate intervention strategy. As Quinsey (1998: 419) noted "with the exception of antiandrogenic medication or castration, this model is currently the only approach that enjoys any evidence of effectiveness in reducing sexual recidivism."

## **Recidivism**

Reliance on measures of recidivism as reflected through official criminal justice system data obviously omit offences that are not cleared through an arrest or those that are never reported to the police. This distinction is critical in the measurement of recidivism of sex offenders. For a variety of reasons, sexual assault is a vastly underreported crime. The United States National Crime Victimization Surveys (Bureau of Justice Statistics) conducted in 1994, 1995, and 1998 indicate that only 32 percent (one out of three) of sexual assaults against persons 12 or older are reported to law enforcement. A three-year longitudinal study (Kilpatrick, Edmunds, and Seymour, 1992) of 4,008 adult women found that 84 percent of respondents who identified themselves as rape victims did not report the crime to authorities. (No current studies indicate the rate of reporting for child sexual assault, although it is generally assumed that these assaults are equally underreported.) Many victims are afraid to report sexual assault to the police. They may fear that reporting will lead to the following:

- further victimisation by the offender;
- other forms of retribution by the offender or by the offender's friends or family;
- arrest, prosecution, and incarceration of an offender who may be a family member or friend and on whom the victim or others may depend;
- others finding out about the sexual assault (including friends, family members, media, and the public);
- not being believed; and
- being traumatized by the criminal justice system response.



These factors are compounded by the shame and guilt experienced by sexual assault victims, and, for many, a desire to put a tragic experience behind them. Incest victims who have experienced criminal justice involvement are particularly reluctant to report new incest crimes because of the disruption caused to their family. This complex of reasons makes it unlikely that reporting figures will change dramatically in the near future and bring recidivism rates closer to actual re-offence rates.

Several studies support the hypothesis that sexual offence recidivism rates are underreported. Marshall and Barbaree (1990) compared official records of a sample of sex offenders with "unofficial" sources of data. They found that the number of subsequent sex offences revealed through unofficial sources was 2.4 times higher than the number that was recorded in official reports. In addition, research using information generated through polygraph examinations on a sample of imprisoned sex offenders with fewer than two known victims (on average), found that these offenders actually had an average of 110 victims and 318 offences (Ahlmeyer, Heil, McKee, and English, 2000). Another polygraph study found a sample of imprisoned sex offenders to have extensive criminal histories, committing sex crimes for an average of 16 years before being caught (Ahlmeyer, English, and Simons, 1999).

### **Treatment of sex offenders and re-offending**

When assessing the efficacy of sex offender treatment, it is vital to recognize that the delivery of treatment occurs within different settings. Those offenders who receive treatment in a community setting are generally assumed to be a different population than those who are treated in institutions. Thus, base rates of re-offending behaviour will differ for these groups prior to treatment participation.

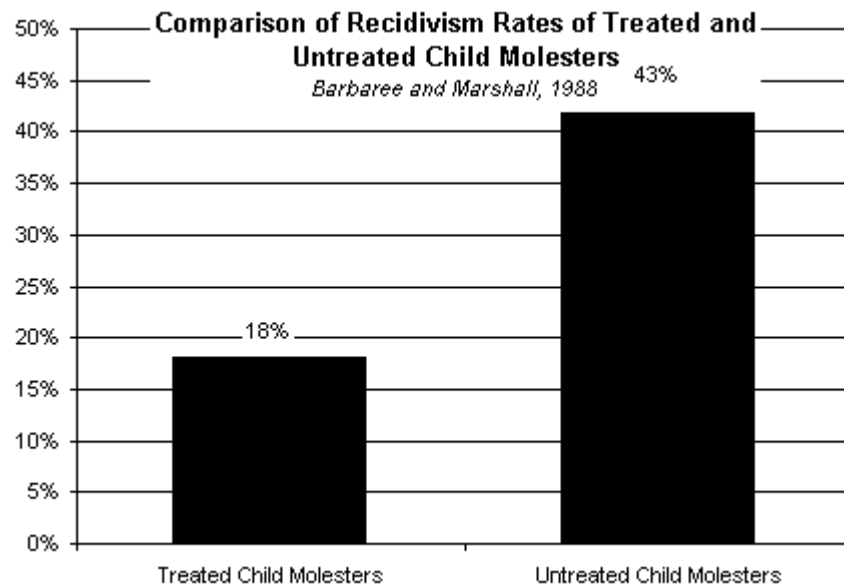
Sex offender treatment typically consists of three principal approaches:

- the *cognitive-behavioural approach*, which emphasizes changing patterns of thinking that are related to sexual offending and changing deviant patterns of arousal;
- the *psycho-educational approach*, which stresses increasing the offender's concern for the victim and recognition of responsibility for their offence; and
- the *pharmacological approach*, which is based upon the use of medication to reduce sexual arousal.

In practice, these approaches are not mutually exclusive and treatment programs are increasingly utilizing a combination of these techniques.

Although there has been a considerable amount of writing on the relative merits of these approaches and about sex offender treatment in general, there is a paucity of evaluative research regarding treatment outcomes. There have been very few studies of sufficient rigor (e.g., employing an experimental or quasi-experimental design) to compare the effects of various treatment approaches or comparing treated to untreated sex offenders (Quinsey, 1998).

Using less rigorous evaluation strategies, several studies have evaluated the outcomes of offenders receiving sex offender treatment, compared to a group of offenders not receiving treatment. The results of these studies are mixed. For example, Barbaree and Marshall (1988) found a substantial difference in the recidivism rates of extra-familial child molesters who participated in a community based cognitive-behavioural treatment program, compared to a group of similar offenders who did not receive treatment. Those who participated in treatment had a recidivism rate of 18 percent over a four-year follow-up period, compared to a 43 percent recidivism rate for the non-participating group of offenders.



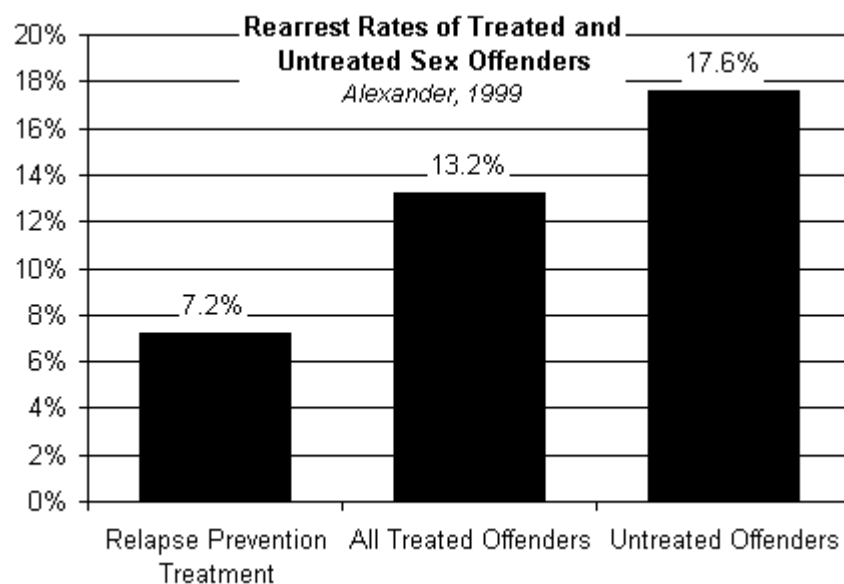
However, no positive effect of treatment was found in several other quasi-experiments involving an institutional behavioural program (Rice, Quinsey, and Harris, 1991) or a milieu therapy approach in an institutional setting (Hanson, Steffy, and Gauthier, 1993).

On the other hand, an evaluation of a cognitive-behavioural program that employs an experimental design presented preliminary findings that suggest that participation in this form of treatment may have a modest (though not statistically significant) effect in reducing recidivism. After a follow-up period of 34 months, 8 percent of the offenders in the treatment program had a subsequent sex offence, compared with 13 percent of the control group, who had also volunteered for the program, but were not selected through the random assignment process (Marques, Day, Nelson, and West, 1994).

Some studies present optimistic conclusions about the effectiveness of programs that are empirically based, offence-specific, and comprehensive. A 1995 meta-analysis study on sex offender treatment outcome studies found a small, yet significant, treatment effect (Hall, 1995). This meta-analysis included 12 studies with some form of control group. Despite the small number of subjects (1,313), the

results indicated an 8 percent reduction in the recidivism rate for sex offenders in the treatment group. (For the purposes of this study, recidivism was measured by additional sexually aggressive behaviour, including official legal charges as well as, in some studies, unofficial data such as self-report.)

Recently, Alexander (1999) conducted an analysis of a large group of treatment outcome studies, encompassing nearly 11,000 sex offenders. In this study, data from 79 sex offender treatment studies were combined and reviewed. Results indicated that sex offenders who participated in relapse prevention treatment programs had a combined re-arrest rate of 7.2 percent, compared to 17.6 percent for untreated offenders. The overall re-arrest rate for treated sex offenders in this analysis was 13.2 percent. (Length of follow-up in this analysis varied from less than one year to more than five years. Most studies in this analysis indicated a three to five year follow-up period.)



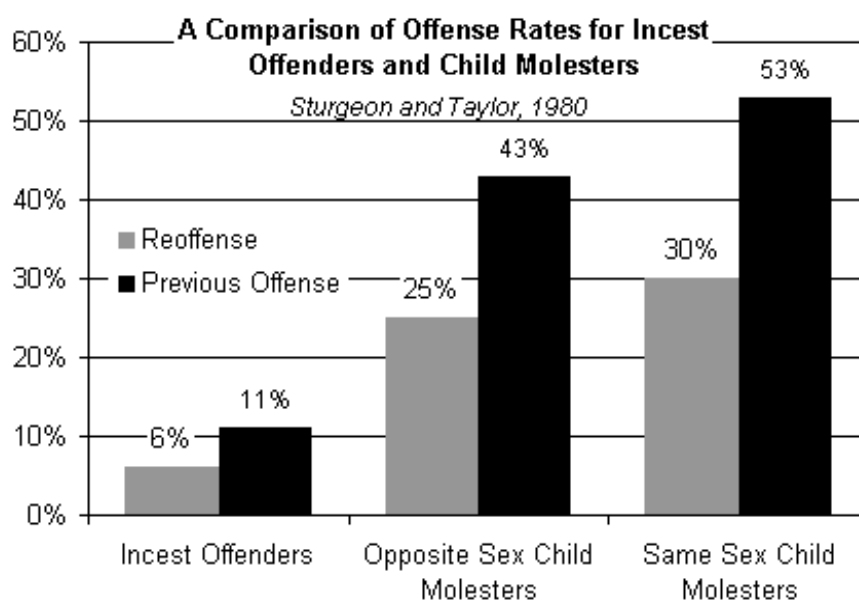
The Association for the Treatment of Sexual Abusers (ATSA) has established a Collaborative Data Research Project with the goals of defining standards for research on treatment, summarizing existing research, and promoting high quality evaluations. As part of this project, researchers are conducting a meta-analysis of treatment studies. Included in the meta-analysis are studies that compare treatment groups with some form of a control group (average length of follow-up in these studies was four to five years). Preliminary findings indicate that the overall effect of treatment shows reductions in both sexual recidivism, 10 percent of the treatment subjects to 17 percent of the control group subjects, and general recidivism, 32 percent of the treatment subjects to 51 percent of the control group subjects (Hanson, 2000).

Just as it is difficult to arrive at definitive conclusions regarding factors that are related to sex offender recidivism, there are similarly no definitive results regarding

the effect of interventions with these offenders. Sex offender treatment programs and the results of treatment outcome studies may vary not only due to their therapeutic approach, but also by the location of the treatment (e.g., community, prison, or psychiatric facility), the seriousness of the offender’s criminal and sex offence history, the degree of self-selection (whether they chose to participate in treatment or were placed in a program), and the dropout rate of offenders from treatment.

### Child sex offenders and re-offending

Studies of the recidivism of child molesters reveal specific patterns of re-offending across victim types and offender characteristics. A study involving mentally disordered sex offenders compared same-sex and opposite-sex child molesters and incest offenders. Results of this five-year follow-up study found that same-sex child molesters had the highest rate of previous sex offences (53 percent), as well as the highest reconviction rate for sex crimes (30 percent). In comparison, 43 percent of opposite-sex child molesters had prior sex offences and a reconviction rate for sex crimes of 25 percent, and incest offenders had prior convictions at a rate of 11 percent and a reconviction rate of 6 percent (Sturgeon and Taylor, 1980). Interestingly, the recidivism rate for same-sex child molesters for other crimes against persons was also quite high, with 26 percent having reconvictions for these offences. Similarly, a number of other studies have found that child molesters have relatively high rates of nonsexual offences (Quinsey, 1984).



Several studies have involved follow-up of extra-familial child molesters. One such study (Barbaree and Marshall, 1988) included both official and unofficial measures of recidivism (reconviction, new charge, or unofficial record). Using both types of measures, researchers found that 43 percent of these offenders (convicted of sex offences involving victims under the age of 16 years) sexually re-offended within a four-year follow-up period. Those who had a subsequent sex offence differed from

those who did not by their use of force in the offence, the number of previous sexual assault victims, and their score on a sexual index that included a phallometric assessment (also referred to as plethysmography: a device used to measure sexual arousal (erectile response) to both appropriate (age appropriate and consenting) and deviant sexual stimulus material). In contrast to other studies of child molesters, this study found no difference in recidivism between opposite-sex and same-sex offenders.

In a more recent study (Rice, Quinsey, and Harris, 1991), extra-familial child molesters were followed for an average of six years. During that time, 31 percent had a reconviction for a second sexual offence. Those who committed subsequent sex offences were more likely to have been married, have a personality disorder, and have a more serious sex offence history than those who did not recidivate sexually. In addition, recidivists were more likely to have deviant phallometrically measured sexual preferences (Quinsey, Lalumiere, Rice, and Harris, 1995).

In a study utilizing a 24-year follow-up period, victim differences (e.g., gender of the victim) were not found to be associated with the recidivism (defined as those charged with a subsequent sexual offence) of child molesters. This study of 111 extra-familial child molesters found that the number of prior sex offences and sexual preoccupation with children were related to sex offence recidivism (Prentky, Knight, and Lee, 1997). However, the authors of this study noted that the finding of no victim differences may have been due to the fact that the offenders in this study had an average of three prior sex offences before their prison release. Thus, this sample may have had a higher base rate of re-offence than child molesters from the general prison population..

# Treatment of Child Sex Offenders

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The overarching aim of intervention with offenders is to protect victims and potential victims; effective intervention must be focused on the offender taking full responsibility for the feelings, thoughts and behaviour that support his offending predicated on the premise that male sexual arousal is controllable. The goal of intervention is to ensure that sex offenders can control their behaviour so that they do not re-offend or sexually abuse others.

Psychological interventions give offenders skills to help them manage their own behaviour. Cognitive behavioural interventions have largely super-ceded primarily behavioural therapies such as aversion therapy, covert sensitisation, and imaginal desensitisation.

While there is much debate around the mandatory exposure to treatment programs for sex offenders (including the need for offenders to admit guilt and be voluntarily willing to attend rehabilitation programs), Bravehearts believes that all sex offenders must complete a treatment program.

## **Cognitive Behavioural Interventions**

Programs based on cognitive-behavioural principles usually include several components. Most are prison-based, but a few are community-based programs. Offenders are usually treated in groups.

A cognitive-behavioural program targets several areas of the offender's thinking and behaviour (Craissati, 1998):

- Breaking down denial and minimisation,
- Developing victim empathy,
- Challenging justifications and cognitive distortions,
- Addressing low self-esteem, fear of adult intimacy and inappropriate assertiveness,
- Modifying and controlling deviant sexual fantasies, and
- Helping offenders to recognise risky situations, feelings, moods and thoughts, and to develop strategies to prevent relapse.

Programs may also deal with relationship issues, basic sex education, anger management, relaxation skills, basic living skills and alcohol and drug awareness (Woods, 1997).

Based on their recent study of offender characteristics, Smallbone and Wortley (2000) advocated that, given that many offenders are in fact involved in a broad range of criminal activity, general offender programs are important alternatives.

This would allow the specialised programs to concentrate on the more persistent sexual offenders.

## **Cognitive Behavioural Programs in Australia**

In Australia, a range of treatment programs have been adopted in the different states targeting different offender populations. Some programs are for convicted offenders in prison. Others target juvenile offenders.

In Australia, there are in-prison treatment programmes for paedophiles in 4 states – NSW, Victoria, Queensland and Victoria. While there have been some in-house studies of these programmes, no formal external evaluations have been carried out (Donato, Shanahan and Higgins, 1999).

This section provides information on some of the cognitive behavioural treatment programs for paedophiles. While it is not a comprehensive dossier, it highlights the specific characteristics and achievements of several different kinds of program.

### **NSW - Juvenile Sex Offender Program**

The NSW Department of Juvenile Justice runs this program for convicted offenders who have committed offences before the age of 18 years. It commenced in 1991/92 and was developed by the NSW Child Protection Council. It is aimed at reducing both sexual and non-sexual offending, helping the offender take responsibility for his actions, and to encourage the development of a positive identity and non-abuse sexuality (Woods, 1997).

This service is only available to juvenile offenders who have been charged. As many juvenile offenders are not charged, particularly if they are very young, they may not get access to any form of help (NSW Child Protection Council, 1996).

### **NSW Pre-Trial Diversion Of Offenders Program**

This was established by the Pre-Trial Diversion of Offenders Act 1985 which applies to a person charged with an offence against their own child, or their spouse / de-facto's child. It operates over two years and offers a combination of various forms of intervention including both individual and group sessions and conjoint work where appropriate (Woods, 1997).

### **Western Australia - Sex Offenders Treatment Unit (SOTU)**

This program, which uses cognitive/behavioural and relapse prevention precepts, has been operating in 3 WA jails (Casuarina, Bunbury and Albany) since 1987. The SOTU also provides expert advice to sentencing and releasing authorities on the management and treatment of sex offenders.

Participation in the program is mandatory if the offender wishes to be considered for early release. Offenders may participate in programs ranging from a 4-month model

to the more intensive 9-month model. Topics covered include victim empathy, human sexuality, anger management and social skills. Every man must state his crime to the group, and talk in detail about it. "One exercise requires them to see the crime through their victim's eyes, and to write their own script for reading to the group." The program has a strong focus on the prevention of offending after release and emphasises the avoidance of high-risk situations (The West Australian, 4 Sep 2000; Donato, Shanahan and Higgins, 1999).

This program has been evaluated positively. Recidivism rates by male offenders who participated in the intensive and pre-release prison-based program from 1990 to 1995 were encouraging (Woods, 1997).

### **Victoria - Adolescent Sex Offender Treatment Program (ASOTP)**

The Children's Protection Society in Victoria established this Program in December 1994. The rationale for its development were:

- Sexual abuse by adolescents was a significant problem,
- No help was available for these adolescents unless they had been charged and placed on order above Probation,
- Early intervention would prevent further victims, and
- Adolescents are more amenable to treatment, and there is greater potential for their behaviour to be changed, (Flanagan and Hayman-White, 1999)

The Program involved group therapy for the participants. Each group member stayed in the group for 12-18 months, and then moved to a Relapse Prevention stage. The Program included a number of modules requiring the client to: take responsibility, gain understanding and insight, develop fantasy control, develop victim empathy, develop social skills, and develop their own Relapse Prevention Plan.

The 1999 Report of the Children's Protection Society analysed the results of the Program for 134 clients. It concluded that, after 12 months: "to the best of our knowledge, no clients who have completed the Program have sexually re-offended" (Flanagan and Hayman-White, 1999).

### **QLD - Sexual Offenders Treatment Program (SOTP)**

The SOTP is for offenders at the Moreton Correctional Centre. From its establishment in 1990 to June 2000, this program dealt with more than 350 sexual offenders. It is based on cognitive-behavioural precepts and covers relapse prevention, anger management and substance abuse. It also pays attention to special needs groups, including indigenous sexual offenders. The program is designed to take 12 offenders 3 times each year and it takes 12 months to complete. After release, offenders can attend community-based maintenance groups over a period of 20 weeks (Donato, Shanahan and Higgins, 1999, Smallbone and Wortley, 2000).



## Overall Evaluations of Cognitive Behavioural Interventions

### A Meta-Analysis Of Treatment Studies.

Hall (1995) summarised the results of 12 studies of “treatments” of sex offenders. The studies that he considered included paedophiles as well as convicted rapists, and exhibitionists. Each of the studies provided a treatment group and a comparison group.

The following table lists each of the studies, and shows the recidivism rates for both the “treatment” groups and the “no treatment” or comparison groups.

Table 1. A Meta-analysis of Sex Offender Treatment Studies (Source: Hall 1995)

Study	Number of Subjects	Recidivism (ratio and rate)	
		Treatment	Comparison
Borduin et al. (1990)	16	.12 (1/8)	.75 (6/8)
Federoff et al. (1992)	46	.15 (4/27)	.68 (13/19)
Hanson et al. (1993)	197	.44 (47/106)	.38 (35/91) *
Hildebran & Pithers (1992)	90	.06 (3/50)	.33 (13/40) *
Maletzky (1991)	200	.10 (10/100)	.06 (6/100)
Marques et al. (1994)	299	.08(9/106)	.13 (25/193) *
Marshall & Barbaree (1988)	126	.13 (9/68)	.34 (20/58) *
Marshall et al (1991)	61	.32 (13/40)	.57 (12/21) *
McConaghy et al (1988)	25	.20 (2/10)	.13 (2/15)
Meyer et al (1992)	61	.42 (17/40)	.57 (12/21)
Rice et al (1991)	58	.38 (11/29)	.31 (9/29)
Wille & Beier (1989)	134	.03 (3/99)	.45 (16/35)
<b>Total</b>	<b>1313</b>	<b>.19 (129/683)</b>	<b>.27 (169/630)</b>

Hall concluded that “treatment” effectively reduced recidivism. With treatment 19% of sex offenders would re-offend, and with no treatment, or the comparison treatment 27 % of sex offenders would re-offend.

While the overall results are encouraging, it must be acknowledged that the studies were very heterogeneous in nature, and this detracts from the usefulness of the meta-analysis. The studies used slightly different populations (ie not all paedophiles), different programs (including cognitive, behavioural, hormonal, and group therapies, and psychotherapy and interpersonal therapy) different lengths of treatment, and different lengths of follow-up.

Five studies (as starred) compared “treatment” with “no treatment”. Except for the Hanson et al study, re-offending rates were lower in the “treatment” groups (ranging

from 6 percent to 32 percent) than in the “no treatment” groups (ranging from 33 percent to 57 percent).

### **The NSW Child Protection Council’s Conclusions, 1996**

In their 1996 report on the management of sex offenders, the Council concluded that: “research into the effectiveness of treatment programs has produced ambiguous and conflicting results . . . further research, both short and long term is required before the success of treatment in modifying offenders’ behaviour can confidently be asserted” (NSW Child Protection Council, 1996).

### **Glaser, 1996**

More favourably, William Glaser (cited in Woods Royal Commission Report, 1997)) considered that: “some recent work does suggest that, generally, treated sex offenders re-offend less, and also less often than their untreated counterparts” (Woods, 1997). He summarised this work as suggesting that:

- “Programs that are more comprehensive in nature tend to be more successful than those with limited aims.
- Institutional and community-based programs appear to produce similar results.
- The best treatments are those which use cognitive-behavioural principles and/or pharmacological measures, and
- There are no consistent predictors of treatment outcome, although motivation for treatment seems very important” (Woods, 1997).

### **The Woods Royal Commission, 1997**

The Woods Royal Commission Report was doubtful about the value of treatment of paedophiles. It noted that there was “uncertainty and lack of definitive empirical research as to whether treatment is of long term value in reducing recidivism, let alone any convincing comparative study of the modalities of treatment offered.” (Woods,1997)

## **Recommendations**

The following discussion summarises the recommendations made by the NSW Child Protection Council and the Woods Royal Commission on the treatment programs that should be adopted in Australia for paedophiles.

### **NSW Child Protection Council, 1996**

From its analysis of the existing services available to help paedophiles stop offending, the NSW Child Protection Council (1996) came up with preferred policy options in several areas.

First, it specified the need to help children under the age of 10 who sexually abuse other children. It observed that there was a wide variation in individual worker’s perceptions of the seriousness of this behaviour. Further, there was “no single organisation with clear responsibility for managing them, and . . no specialist treatment programs for this age-group” (p29). Finally, the Council observed that the

legislation governing the activities of the Department of Community Services gave it no power to intervene when a child is a perpetrator.

The NSW Child Protection Council's recommendations for perpetrators in this age group emphasised more comprehensive assessment and treatment services, and changes to the Children (Care and Protection) Act 1987 to include children who are sexual abusers.

For juvenile offenders (aged 10 to 17 years) it recommended the expansion of the Juvenile Justice Department's Juvenile Sex Offenders' Program within an overall framework of court mandated programs. It considered that, in most cases, and more so than at present, a juvenile perpetrator should be charged, thus acknowledging the seriousness of the crime.

In respect of adult offenders, the Council recommended:

- A co-ordinated statewide approach,
- That following conviction perpetrators should receive either a custodial sentence, or a non-custodial sentence accompanied by a "community-based management program" and "mandatory supervision" in the community,
- That after release on parole, offenders must go through a management program, including supervision and monitoring of their access to children, and
- That the current 3 year limit on mandatory supervision be extended to 5 to 10 years, and possibly to 10 to 15 years.

Their recommendations for treatment programs were (p13):

- They must be legally mandated
- They must be piloted, monitored and independently evaluated,
- They must be staffed by appropriately trained professionals, and
- They must be linked to research into long term outcomes.

### **Woods Royal Commission, 1997.**

Its recommendations were:

- The establishment of a prison based program
- The continuation of the psycho-sexual education programs for offenders serving short sentences
- The establishment of accredited community-based programs, including residential and outpatient facilities, for those serving non-custodial sentences and those who voluntarily seek treatment,
- Sentencing options to included participation in a "treatment program";
- That Community Service Orders not be a sentencing option;
- Monitoring of a program established by the Catholic Church to address sexual abuse by Catholic Priests,
- Review and co-ordination of the available services,
- Development and extension of services for the adolescent offender, and the intellectually disadvantaged offender,

- Changes to the Children (Care and Protection) Act to cover children who are sexual abusers (echoing the NSW Child Protection Council),
- Training and research, and
- An accreditation system for all services and therapists.

## Medical Interventions

Some countries have adopted surgical and medical castration as an intervention with paedophiles and sex offenders generally.

Medical castration involves the administration of drugs such as Depo Provera, or MPA, which is a synthetic steroid that counteracts the sex hormones, (i.e. testosterone). Money (1972, cited in Smith and Chapman, 1999) noted that it produces the “loss of the capability of erection and ejaculation . . . a concomitant reduction of the feeling of sexual urge or lust . . . a loss of drive”. Some side effects are: a reduction in fertility, increased blood pressure, weight gain, hot flushes, fatigue, headaches, sleep disturbance, disturbances in sugar and lipid metabolism, and breast enlargement (Woods Royal Commission Report, 1997).

Surgical castration has been more widely adopted as a procedure for rapists. For example, from 1935 to 1970 Denmark gave sex offenders the choice of prison or surgical castration. Following criticism the practice was banned, and replaced in 1973 by medical castration accompanied by therapy. Chemical castration of offenders is also practised in Sweden and Germany and the US. By 1998 six US states had adopted some form of biochemical treatment of sex offenders, and five had Bills under consideration (Myers, R., 1998). However, because chemical castration is very expensive (\$70,000 per offender for repeat treatments) surgical castration is favoured in some US states. In the states of Florida and Montana there is provision for involuntary surgical castration after a single offence.

Sturup (1972, cited in Smith and Chapman, 1999) found recidivism rates of less than 10% in mixed groups that had been surgically castrated. His sample was 900 men who had been castrated between 1929 and 1959, and he concluded that: “castration seems no more harmful to a man’s potential to live a normal life than the alternative of a very long imprisonment”.

Some US studies have reported positive results for medical castration. One study reported a recidivism rate of 15% for offenders on this medication, compared with 68% in the control group. Another study reported 18% recidivism by the treatment group, 35% recidivism by those after they stopped taking the medication, and 58 % recidivism by those who received no treatment at all (Myers, R., 1998). The Observer (06/08/01) reported a Texas study showing that the two different kinds of castration produced a repeat offender rate of 2.2 percent compared with 20 to 50 percent for uncastrated paedophiles.



# Management of Child Sex Offenders

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## **Community (Post-Prison) Management**

There is a strong possibility that many convicted paedophiles will re-offend when they are released into the community after a prison sentence, even if they have completed a treatment and behaviour management program.

Given this likelihood, there is a need for post-prison follow-up of paedophiles. Community management options that impose the fewest restrictions on a paedophile's activities pose the greatest risk to children's safety. Conversely, management options that impose the greatest intrusiveness into the paedophile's autonomy enhance children's safety. Various options for the post-prison management of sex-offenders, in terms of this continuum, are discussed as follows. They are: paedophile registers, supervision in the community, communal custody arrangements and indefinite sentencing.

## **Paedophile Registers**

In recent years there has been considerable public debate in the US and the UK about the need for public versus police registers of paedophiles. Bravehearts position on registers and specifically community notification laws, has been expanded on in our Position Paper, "Community Notification of Sex Offenders".

### **US Paedophile Registers**

Since 1994, the US federal government has required states to keep registers of the locations of convicted sex offenders, including child sex offenders, upon their release. This is a condition of receiving federal crime-fighting funding. The legislation (also known as Megan's Law) also requires that state laws provide for annual re-registration of offenders, continuing for at least 10 years, and for a registered offender's personal information to be disclosed for the protection of the public (Woods Royal Commission Report, Vol V, 1997). To enhance individual state monitoring of paedophiles, provision was made in 1996 for a national database of registered sex offenders, thereby allowing the FBI to track their movements between states (Woods Royal Commission Report, 1997).

Different US states have different versions of this legislation. Some US states make information about sex offenders available to the general public at local police stations. In some states people must write in requesting details about sex offenders, or they can call a toll-free telephone number. In twenty-one US states (most of them in the South and mid-West), sex offenders may have their names, photos and addresses broadcast over the Internet. By mid-2000, New Jersey became the 30<sup>th</sup> state with some kind of Internet Sex Offender register. In some states the police have the authority to hand out fliers or contact employers in relation to offenders deemed to be especially dangerous (Schoenberg, 1999)

In some states, eg Washington and New York, Megan's law provides for 3 levels of sex offenders and different levels of notification. In the state of New York no information is given out about sex offenders who are graded at the lowest level of risk.

In 1999, LA became the first city in the US to send warning letters to residents when an offender moved into their neighbourhood. The notice included a photograph, details of the abuser's record, and a request to keep an eye on him but to leave him alone.

### **UK Paedophile Registers**

In the UK, monitoring of convicted paedophiles is provided for under the Sex Offender Orders Act. The Act allows the police and its agencies to monitor and share information on sexual offenders. A person subject to a Sex Offender Order must register his name, aliases and any changes in his name, his date of birth, and his address plus any changes to that address. The Order includes prohibitions on the behaviour of the individual. There is provision for disclosure of information to other professionals and also, potentially, to members of the public. The length of registration varies according to the original sentence, and may be for life (Morrison, 1999).

It has been reported that there is 97 percent compliance with these requirements (HOGE, Aug 7, 2000). The loopholes are:

- Some offenders fail to register, (some 375 offenders, out of 13,400 failed to register their whereabouts with police (Courier Mail, 25 Oct 2000)),
- Some offenders abscond, or disappear,
- Individuals can "holiday" for up to 14 days without notifying police, and
- Registers cannot be made retrospective.

In the year 2000, the UK was moving to put in place its own Megan's Law, to be known as Sarah's Law. The draft legislation provided that police and probation officers would be able to set up "risk panels" to assess dangerous released offenders. In each police area, the public will have access via a web-site or other publication to figures about the number of sex offenders locally, but not their names and addresses (Courier Mail, 25 Oct 2000)

### **Australian Registers Of Paedophiles.**

In Queensland the courts are currently empowered to make Orders against child sex offenders at the time of sentencing, requiring them to keep police informed of their whereabouts after being released. Under Section 19 of the Qld Criminal Code, the Orders apply when a court is: "satisfied that a substantial risk exists that the offender will thereafter commit any further offence of a sexual nature" against a child.

In 1997, the Woods Royal Commission recommended that a national register of sex offenders be established. The Commission did not favour the introduction of a "Megan's Law" in Australia that would provide for a public register of paedophiles, preferring a register and database for the law enforcement agencies.

### **The Debate over Public versus Police Registers of Paedophiles**

The arguments over a public register of convicted paedophiles compared with a police register have been well canvassed. The main arguments in favour of a public register are as follows: (Woods Royal Commission Report, 1997, Vol V, p 1223).

- The public has a right to know that an offender is living nearby, so that they can take precautions.
- A public register could be a greater deterrent to new offences as the offender knows he is being monitored.
- Victims feel more secure knowing their abuser is being monitored.
- Community anger is soothed (Gadher and Harlow, 2000)
- Arrests happen more quickly (Gadher and Harlow, 2000)
- “Maybe its doesn’t reduce the number of sexual attacks on children, but you can never tell how many shipwrecks a lighthouse has prevented” (pers comm. Roxanne Lieb, in Gadher and Harlow, 2000)

The main arguments against a public register are as follows: (the Woods Royal Commission Report, 1997)

- The register may inadvertently reveal the name of the victim.
- The register may brand innocent members of the paedophile’s family.
- There may be victimisation of innocent individuals whose names are confused with those of abusers.
- There may be encouragement of community anger, lawlessness.
- If there is no grading, so that lower risk offenders’ names are kept off the public register, the public register may “brand” all offenders, reduce their privacy, and subject them to harassment by vigilantes. If offenders are hounded from place to place, the stress may influence them to re-offend. (In the UK a paedophile was hounded out of more than 10 hotels/motels and 3 homes/apartments after authorities notified his neighbours.)
- Registered paedophiles more likely to “disappear”.
- Released paedophiles are less likely to register. A much higher percentage of paedophiles register in the UK where the registers are not made public. It is much harder for police to keep track of unregistered offenders.
- Community notification is of little use in improving the safety of children unless adults accompany children at all times in public.
- Offenders may take more drastic steps to cover up their offence.
- It is a double-punishment of the offender, and unfair as eg released murderers do not have similar requirements put on them.
- The community is lulled into a false sense of security, whereas most paedophiles are never charged or convicted.
- Greater expenditure on a public register may be needed (c.f. a police register) that could be otherwise better spent chasing offenders.

In 2000 the Observer newspaper reported that Megan’s law had “failed to protect victims and failed to prevent offenders from repeating their crimes”. Further, it considered that it was a “nightmare” for the police to administer properly.

## **Supervision In The Community**

In NSW, the sentence of supervised recognisance provides for some supervision of sex offenders in the community. It allows the Probation Service to monitor the offender's access to children – in the home, at work and at social settings (NSW Child Protection Council, 1996). The NSW Probation Service also monitors offenders post-prison on parole.

In their 1992 study of recidivism by Western Australian sex offenders (Broadhurst and Maller, cited in Smith and Chapman, 1999) found that re-offending was less likely during the period of parole supervision, but that it continued to increase steadily after release.

In Maricopa County, Arizona, US, imprisoned sex offenders must agree to a lifetime of community supervision as a condition of their release from prison. This includes a lifetime of probation, attendance at weekly counseling sessions, and submission to routine lie detector tests and unannounced in-home inspections by surveillance officers. Statistics on the program found that between 1993 and 2000 only 6.8 percent of the program's participants had committed further sex offences (Centre for Sex Offender Management, 2001). This can be compared to the recidivism rate for further sex offences as reported in Hanson and Bussiere's meta analysis of sex offender recidivism (1998).

Supervision of released paedophiles in the community could include electronic bracelets. The US state of Illinois operates an electronic tagging system for sex offenders. Offenders are given 2 years "home detention" and made to wear a computer tracing device for two years after being released from jail (The Observer, 06/08/00)

## **Communal Custody**

An even more restrictive option would be to require paedophiles to live in communal custody – in special guarded communities where no children are allowed. They could lead nearly normal lives, perhaps living with their spouses, and holding a job within the community, but they would be required to wear electronic bracelets and would not be able to leave the confines of the community. Other community residents would be free to come and go as they wished. This option would be considerably less expensive than keeping the offender in prison, or in a mental hospital, and would offer more safety to children than registration systems (Legal Times, 1999, Etzioni, 2000).

A trial of a communal custody arrangement recently operated in Nottingham prison in the UK. Offenders deemed to be "a risk to public safety" were kept in prison residential areas. Visitors were subject to police checks and under 18 year-olds and other paedophiles were disallowed entry (Courier Mail, 2 Sep 2000).



More widely in the UK, there is a system requiring convicted offenders to live in probation hostels with specific monitoring and supervision. They must also agree to register under the Sex Offender Orders Act for at least 5 years, and comply with other conditions, which may include electronic tagging. The new Criminal Justice Act has also placed a duty on police and probation services to “look after” all convicted sex offenders on their patch.

## **Indefinite Prison Sentences**

In the US, recent legislation provides for violent sexual offenders to be committed to mental hospitals after they have completed their prison sentences. This legislation, known as the Sexually Violent Predator Law, or “Stephanie’s Law”, (after the rape and murder of Kansas schoolgirl Stephanie Schmidt) was first introduced in the US state of Kansas. It allows the State to lock up sexual offenders indefinitely, if they are judged to be mentally abnormal and likely to commit “predatory acts of sexual violence”. They are put into state mental hospitals the day they complete their jail sentences. By 1999, 14 other US states had similar laws.

This legislation has faced considerable controversy. Although it is acknowledged that, it provides a high degree of public safety against those particular offenders there are several valid arguments against it. The US psychiatric profession argued that the statute’s definitions were being used to turn offenders into mental patients, and that it was “an abuse of the mental health care system” (Legal Times, 1999). It was also argued that the practice strips away the basic rights of offenders, depriving them of their privacy and autonomy (Legal Times, 1999).

Other draft legislation being considered by the US Senate in July 2000 - The No Second Chances for Murderers, Rapists or Child Molesters Act, (Aimee’s law) would further discourage US states from releasing murderers, rapists and child molesters. It penalises them financially if released offenders are re-arrested in another state. States that maintain stiff penalties against these offenders are to be financially rewarded.

Life sentences for paedophiles were also recently considered in the UK, after the murder of Sarah Payne. In particular, some UK politicians called for life sentences for paedophiles who become repeat offenders (Aug 13, 2000, COMMENT). While repeat offenders convicted of raping children under 13 are already subject to automatic life sentences, it was argued that other serious sexual offences against children should also be subject to a life sentence.

In Qld, Section 18 of the Criminal Law Amendment Act (1945) provides for indefinite detention in some cases. Further, Part 10 of the 1992 Penalty and Sentences Act allows the court to impose an indefinite sentence on an offender convicted of ‘violent’ offences, including a range of ‘serious’ sexual offences, if the court is satisfied that the offender is a serious threat to the community.

## **Queensland's Dangerous Prisoners (Sexual Offenders) Act 2003**

Bravehearts successfully advocated for the introduction of indefinite sentencing in Queensland. In 2003 the Queensland Government passed the *Dangerous Prisoners (Sexual Offenders) Act 2003*. The Act has been demonstrated to work, and has withstood a High Court challenge asserting that it breached the Australian Constitution. It clearly does not.

The *Dangerous Prisoners (Sexual Offenders) Act 2003* was introduced to address growing community concern about the unsupervised release of convicted sex offenders who were not rehabilitated. The Act enables the Supreme Court to order the post-sentence preventative detention or supervision of prisoners serving sentences for serious sexual offences who pose a significant danger to the community upon release from prison.

Since the commencement of the Act on 6<sup>th</sup> June 2003, officers within the Queensland Department of Justice and Attorney-General and the Department of Corrective Services have worked together to modify the established systems which have been established for the early identification of those sexual offenders who may be suitable for an application under the *Dangerous Prisoners (Sexual Offenders) Act 2003*.

A key element in the system is the Serious Sexual Offenders Review Committee (SSORC), an inter-departmental committee consisting of senior officers from the Department of Justice and Attorney-General, Department of Corrective Services and the Queensland Police Service. SSORC considers all sexual offenders serving more than two years for referral to Crown Law for advice to the Attorney-General on those offenders considered to be an unacceptable risk to the community after release.

SSORC considers sexual offenders at least 18 months before those offenders' earliest release dates from prison. This allows time for the preparation of the necessary psychiatric reports, as well as time for the preliminary and final hearings in court, before the offender can be released.

## **Polygraph Tests and Monitoring of Child Sex Offenders**

The polygraph instrument is a relatively simple device that measures heart rate, blood pressure, respiration and electrodermal changes. These physiological changes are measures without any discomfort to the subject. In respect to child sex offenders, the polygraph is used as a tool to determine compliance with counselling objectives and conditions of probation.

Polygraphs are perhaps the most controversial tool in law enforcement. It has been argued that there is no real consensus that polygraph evidence is reliable, with the scientific community polarised on the matter. However, both the reliability and

validity of polygraph methodology have continued to improve over the past decade, which has enhanced their accuracy and validity.

The purpose of the polygraph examination is to verify the perpetrator's completeness regarding offence history and compliance with therapeutic directives and terms of supervision (Edson, 1991, Emerick and Dutton, 1993). Thus, when the polygraph is used as a treatment tool it increases the accountability of an offender living in the community. In a 1990 research study, Humbert found that when a polygraph was utilised during the latter part of sex offender treatment, there was a 600% increase in the number of sexual perpetrations reported originally. Taking this information into consideration, the usefulness of the polygraph in sex offender therapy cannot be underestimated when considering that paedophilia "is a disorder maintained largely by the offender's ability to deny, justify, and rationalise the behaviour" (Hagler, 1995, p.104).

The polygraph has become an important tool in treatment and supervision of child sex offenders because it provides independent information about compliance with release conditions and progress in therapeutic programs. In the United States polygraph tests are utilised in parole in 14 states. In addition, in a number of states polygraph testing is required or provided for through state sex offender treatment standards and/or legislation (California Research Bureau, 2004). A number of states also use, or only use, polygraph tests as a tool for post-release monitoring and aftercare (Colorado Department of Corrections, 2000)

The use of the post-release polygraph is becoming a valuable tool in the management and treatment of sex offenders. Both Washington and Oregon have been consistently using polygraphs since the early 1980s. Combined with criminal justice supervision and sex offence-specific treatment, polygraph tests are making a substantial contribution to managing the significant risk that sex offenders present to the public (Cooley-Towell, Pasini-Hill and Patrick, 2000).

The types of polygraph testing used include:

**Instant Offence Disclosure** - This format is used to determine whether the original crime was actually committed by the subject. Denial or rationalisation of this crime, if actually committed, hinders appropriate treatment from being provided.

**Sexual History Disclosure** - Appropriate treatment can only be successful if the subject's complete sexual history is disclosed to the treating psychologist. This format is used to verify whether the subject has withheld pertinent information from his/her background.

**Monitoring Testing** - An important aspect of the monitoring program is to verify that the subject has not committed new sexual offences while in the program. This format is used for exactly this purpose.

**Maintenance Testing** - This format is used to determine any issue related to parole, probation or therapy of specific interest to the psychologist or parole/probation

officer. Some typical uses for this exam would be to determine whether the subject has been in contact with children in violation of parole/probation guidelines, has viewed pornography, has had any contact with a previous victim, or is "grooming" anyone as a new potential victim. (Council on Sex Offender Treatment undated)

# Bravehearts Position

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The following summarises Bravehearts' position on the issues raised in this paper.

## **On treatment programs**

- Bravehearts agrees that cognitive behavioural interventions may reduce the incidence of offending with some paedophiles, and supports the continuation of their use.
- Bravehearts upholds programs that target child sexual assault by adolescents and children to reduce the incidence of adult paedophilia.
- Bravehearts supports the need for comprehensive external evaluation studies of the existing programs in Australia.
- Bravehearts supports mandatory treatment for all child sex offenders.

## **On surgical and medical castration**

- Bravehearts advocates that further investigation of the options of medical and surgical castration of some paedophiles in Australia as a condition of their prison release be seriously considered.

## **On a Register of Paedophiles**

- Bravehearts supports the establishment of a national register of paedophiles, one that allows the movement of paedophiles between States to be monitored
- Bravehearts supports the establishment of a police rather than a public register of paedophiles.

## **On Communal Custody Arrangements**

- Bravehearts considers that the option of communal custody arrangements, including the use of electronic bracelets, for paedophiles in Australia should be further studied

## **On Indefinite Prison Sentences**

- Bravehearts believe the current legal definition of what constitutes 'violent' and 'serious' in terms of sentencing options needs to be amended to better reflect the serious consequences of child sexual assault on victim's lives and to allow for detainment and risk assessment of convicted offenders prior to release.
- Bravehearts advocate that where a child sex offender is also a murderer of his victim/s, that a mandatory sentence of 'Life –never to be 'released' should apply.

- Bravehearts advocate that the length of detention for child sex offenders be guided by clinical 'risk assessments of re-offending' rather than focusing only on punishment. Offenders who have completed their time but who are clinically assessed as posing a risk of re-offending should not be released.
- Bravehearts does not support the committal of serious paedophiles to mental hospitals upon their release from a custodial sentence.

## **On Polygraph Testing of Child Sex Offenders**

- Bravehearts advocates for further investigation into the use of polygraph testing as part of a battery of assessment and monitoring tools for child sex offenders in Australia.
- Bravehearts recommends that a trial be put in place, guided by current practice in International jurisdictions.

## **Bravehearts recommendations**

Successful treatment and management of child sex offenders needs to include the “successful” completion of a rehabilitation program and successful reintegration into the community, and the continuation of rehabilitation and monitoring post-release.

**It is Bravehearts’ position that all child sex offenders should be sentenced indefinitely with a minimum custodial period set by the judiciary followed by a mandatory conditional release period and on-going monitoring and treatment. This needs to include individually-tailored case management and risk assessment utilising a battery of reliable tools.**

**All offenders should only be considered for release on the completion of their term of detention, and/or when they have demonstrated to the satisfaction of a Community Corrections Board that they have successfully completed rehabilitation and their risk of harm to the community is negligible.**

**Mandatory conditions of the release to continue throughout the post-release period, of any child sex offender need to include:**

- **A clearly defined and communicated management program;**
- **Mandatory post-release treatment programs;**
- **Mandatory, 10-years (for offenders serving less than 5 years) or life-long (for offenders serving 5 years or greater), assessment and monitoring (including periodic psychometric and psychophysiological testing);**
- **The abolishment of any rights to refuse to be interviewed or have residences searched by police in relation to crime investigations;**
- **Conditions that prevent released child sex offenders from associating with other known offenders;**
- **Mandatory requirement for all child sex offenders to *immediately* notify their community corrections worker (who in turn must be required to**

immediately notify the Queensland Police Service) of any change of address or employment and any short or long-term vacations;

- That all sex offenders forfeit passports;
- Conditions that restrict the offender's access to children, including, but not limited to working with children; and
- The right to return the offender to a custodial setting should any conditions of release be breached; in addition to
- Any other conditions deemed appropriate for the individual offender.

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