# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREWORD</td>
<td>1</td>
</tr>
<tr>
<td>RESEARCH TEAM</td>
<td>3</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>4</td>
</tr>
<tr>
<td>1. Accepted group</td>
<td>4</td>
</tr>
<tr>
<td>2. Assessment period</td>
<td>4</td>
</tr>
<tr>
<td>3. Child sexual abuse</td>
<td>4</td>
</tr>
<tr>
<td>4. Completed group</td>
<td>4</td>
</tr>
<tr>
<td>5. Control group</td>
<td>4</td>
</tr>
<tr>
<td>6. Declined group</td>
<td>4</td>
</tr>
<tr>
<td>7. Eligible offenders</td>
<td>5</td>
</tr>
<tr>
<td>8. Estimated lifetime recidivism rate</td>
<td>5</td>
</tr>
<tr>
<td>9. Face-ups</td>
<td>5</td>
</tr>
<tr>
<td>10. Incest</td>
<td>5</td>
</tr>
<tr>
<td>11. Intrafamilial sex offender</td>
<td>6</td>
</tr>
<tr>
<td>12. Noncompleted group</td>
<td>6</td>
</tr>
<tr>
<td>13. Practical significance</td>
<td>6</td>
</tr>
<tr>
<td>14. Relative reduction in recidivism</td>
<td>6</td>
</tr>
<tr>
<td>15. Reoffending data</td>
<td>6</td>
</tr>
<tr>
<td>16. Statistical power</td>
<td>7</td>
</tr>
<tr>
<td>17. Statistical significance</td>
<td>7</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>8</td>
</tr>
<tr>
<td>CHAPTER 1: OVERVIEW OF INTRAFAMILIAL CHILD SEXUAL OFFENDING</td>
<td>11</td>
</tr>
<tr>
<td>1. Definition of intrafamilial sexual offending</td>
<td>12</td>
</tr>
<tr>
<td>2. Previous research on intrafamilial sex offenders</td>
<td>12</td>
</tr>
<tr>
<td>3. The incidence and prevalence of child sexual abuse</td>
<td>14</td>
</tr>
<tr>
<td>4. Child sexual abuse in New South Wales</td>
<td>15</td>
</tr>
<tr>
<td>5. Attrition between reporting and conviction</td>
<td>15</td>
</tr>
<tr>
<td>6. Summary</td>
<td>17</td>
</tr>
</tbody>
</table>
CHAPTER 2: THE NSW PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM CEDAR COTTAGE ............... 18

Establishment of the program .................................................................................................................. 19
1993 Legislative amendments .................................................................................................................. 20
Criteria for referral and admission ........................................................................................................... 21
The treatment program ............................................................................................................................ 26
1992 qualitative evaluation of Cedar Cottage .......................................................................................... 27
1992 recommendations for improvements ............................................................................................. 28
Summary .................................................................................................................................................. 31

CHAPTER 3: COMMUNITY-BASED ADULT SEX OFFENDER TREATMENT PROGRAMS ................. 32

The relevance of theories about intrafamilial sex offending ................................................................... 33
Community-based intrafamilial sex offender treatment programs ......................................................... 37
United States community-based programs ........................................................................................ 38
New Zealand Community-based Programs ......................................................................................... 38
Australian community-based programs .............................................................................................. 39
New South Wales .................................................................................................................................. 39
South Australia ..................................................................................................................................... 39
Western Australia ................................................................................................................................. 40
Summary .................................................................................................................................................. 41

CHAPTER 4: RECIDIVISM AS A MEASURE OF TREATMENT EFFECTIVENESS ............................... 43

The sample ............................................................................................................................................... 44
The indicator event to assess recidivism ................................................................................................. 44
Incidence versus prevalence of reoffending ............................................................................................ 45
Reoffending databases ............................................................................................................................. 46
Base rates of sexual recidivism ................................................................................................................. 46
Length of the observation period ............................................................................................................. 47
Treatment and control groups ................................................................................................................. 48
Benchmarks to evaluate treatment effectiveness ................................................................................... 48
Random controlled trials .......................................................................................................................... 49
Treatment efficacy versus effectiveness .................................................................................................. 50
Interpreting sexual recidivism data ........................................................................................................ 50
Other measures of treatment effectiveness ............................................................................................ 52
Summary .................................................................................................................................................. 52
CHAPTER 5: METHOD AND PROCEDURES ........................................................................................................ 53
Research questions ........................................................................................................................................... 54
Research design .................................................................................................................................................. 54
Procedure ......................................................................................................................................................... 54
  Ethical approval .............................................................................................................................................. 54
  Data collection ................................................................................................................................................ 55
  Interrater reliability ......................................................................................................................................... 56
  Criminal records ............................................................................................................................................ 57
Summary .......................................................................................................................................................... 59

CHAPTER 6: CHARACTERISTICS OF THE SAMPLE, INDEX OFFENCES AND VICTIMS ................................ 60
Time in treatment .............................................................................................................................................. 62
Demographic characteristics of offenders ......................................................................................................... 62
  Aboriginals and Torres Strait Islanders ............................................................................................................ 62
  Offender relationship to victim ....................................................................................................................... 62
  Age of offenders at referral and first abuse ..................................................................................................... 63
  Marital status ................................................................................................................................................ 64
  Employment history ...................................................................................................................................... 65
  History of substance abuse and mental illness ............................................................................................... 66
  Experiences of childhood sexual, physical and emotional abuse ................................................................. 67
  Offender history of criminal conduct ........................................................................................................... 68
  Retrospective STATIC-99 scores .................................................................................................................. 71
Victim characteristics ...................................................................................................................................... 72
Index offence characteristics ........................................................................................................................... 74
Acceptance of responsibility following treatment .......................................................................................... 81
  Face-ups ......................................................................................................................................................... 82
Comparison of offenders referred before and after 1993 .............................................................................. 83
Summary .......................................................................................................................................................... 85

CHAPTER 7: RECIDIVISM FOLLOWING REFERRAL TO CEDAR COTTAGE ................................................... 86
Reoffence rates observed in official police reports and convictions ................................................................. 88
Observed rates of sexual and nonsexual reoffending ....................................................................................... 90
Relative reduction in sexual recidivism rates .................................................................................................. 92
Length of time before relapse (survival analysis) .............................................................................................. 93
Relationship to victim ....................................................................................................................................... 97
CHAPTER 8: CONCLUSIONS ............................................................................................................. 105
Significance of the empirical findings .............................................................................................. 106
Common misperceptions about intrafamilial child sex offenders ...................................................... 107
Effectiveness of the program in reducing relapses and reoffence rates ........................................... 109
The role of acceptance of responsibility in reducing recidivism ...................................................... 111
Cost-effectiveness of the diversion program ...................................................................................... 112
Effective harm reduction and benefits to victims and their families .............................................. 113
Underutilisation of the program: barriers to referrals of eligible offenders ...................................... 113
Diversion as a model of therapeutic jurisprudence and restorative justice ...................................... 114
Summary ........................................................................................................................................... 114

CHAPTER 9: RECOMMENDATIONS .................................................................................................. 115
Dissemination of information about the Cedar Cottage Treatment Program ...................................... 116
Recommendation 1: .......................................................................................................................... 116
Recommendation 2: .......................................................................................................................... 116
Recommendation 3: .......................................................................................................................... 117
Recommendations regarding procedures to continue treatment ...................................................... 117
Recommendation 4: .......................................................................................................................... 117
Recommendation 5: .......................................................................................................................... 117
Recommendation 6: .......................................................................................................................... 118
Recommendation 7: .......................................................................................................................... 118
Recommendation 8: .......................................................................................................................... 118
Recommendations regarding future evaluation and research ........................................................... 118
Recommendation 9: .......................................................................................................................... 118
Recommendation 10: ......................................................................................................................... 119
Recommendation 11: ........................................................................................................................ 119
Summary ........................................................................................................................................... 119

 Fewer victims of reoffences .................................................................................................................. 97
 Fewer reoffences ................................................................................................................................. 98
 Less harmful reoffending conduct .................................................................................................... 99
 Prior offending .................................................................................................................................... 101
 STATIC-99 scores and recidivism ..................................................................................................... 103
 Acceptance of responsibility and recidivism ..................................................................................... 103
 Summary ............................................................................................................................................ 104

CHAPTER 8: CONCLUSIONS ............................................................................................................. 105
Significance of the empirical findings .............................................................................................. 106
Common misperceptions about intrafamilial child sex offenders ...................................................... 107
Effectiveness of the program in reducing relapses and reoffence rates ........................................... 109
The role of acceptance of responsibility in reducing recidivism ...................................................... 111
Cost-effectiveness of the diversion program ...................................................................................... 112
Effective harm reduction and benefits to victims and their families .............................................. 113
Underutilisation of the program: barriers to referrals of eligible offenders ...................................... 113
Diversion as a model of therapeutic jurisprudence and restorative justice ...................................... 114
Summary ............................................................................................................................................ 114

CHAPTER 9: RECOMMENDATIONS .................................................................................................. 115
Dissemination of information about the Cedar Cottage Treatment Program ...................................... 116
Recommendation 1: .......................................................................................................................... 116
Recommendation 2: .......................................................................................................................... 116
Recommendation 3: .......................................................................................................................... 117
Recommendations regarding procedures to continue treatment ...................................................... 117
Recommendation 4: .......................................................................................................................... 117
Recommendation 5: .......................................................................................................................... 117
Recommendation 6: .......................................................................................................................... 118
Recommendation 7: .......................................................................................................................... 118
Recommendation 8: .......................................................................................................................... 118
Recommendations regarding future evaluation and research ........................................................... 118
Recommendation 9: .......................................................................................................................... 118
Recommendation 10: ......................................................................................................................... 119
Recommendation 11: ........................................................................................................................ 119
Summary ............................................................................................................................................ 119
**LIST OF TABLES**

Table 1. Studies comparing intrafamilial and extrafamilial child sex offenders ........................................ 13
Table 2. Outcome of charges and penalties for child sexual offences in NSW courts 2004-2006 .............. 17
Table 3. Number of offenders referred to Cedar Cottage 1989-2007, by group ...................................... 25
Table 4. 1992 Evaluation recommendations and response ................................................................. 28
Table 5. Community-based adult sex offender treatment outcome studies ........................................... 37
Table 6. Key features and outcomes of community-based treatment programs for adult sex offenders 41
Table 7. Offender relationship to victim, by group (percent) ................................................................. 63
Table 8. Age range of offenders at first incident of reported abuse, by group (percent) .................... 64
Table 9. Offender marital status, by group (percent) .............................................................................. 64
Table 10. Offender marital status, by relationship to victim (percent) .................................................. 65
Table 11. Offender employment history, by group (percent) ................................................................. 65
Table 12. Employment status at the time of index offence, by group (percent) .................................. 66
Table 13. Offender history of affective disorder, by substance abuse history (percent, number) .......... 67
Table 14. Age of offender at time of prior offending by group (percent, number) .............................. 70
Table 15. Prior offending reports and conviction, by offence type and group (percent) .................... 70
Table 16. Prior sexual offences by group (percent, number) ............................................................... 71
Table 17. Gender of index victims, by group (percent) ....................................................................... 73
Table 18. Gender of child victims, by offender relationship to victim (percent) ................................... 73
Table 19. Age of youngest index victims, by group (percent) ............................................................... 74
Table 20. Age of youngest victims, by offender relationship to victim (percent) ................................. 74
Table 21. Index offence characteristics (means) ................................................................................... 75
Table 22. Number of charges against offenders at referral, by group ................................................. 75
### Table 23. Number of incidents of abuse in index offences, by group (percent offenders in each group) 76

### Table 24. Abusive acts against the index victim, by group (percent) ........................................................ 76

### Table 25. Number of abusive acts committed in one-off index offences, by group (percent) ........................ 77

### Table 26. Intrusiveness of abuse in one-off index offences, by group (percent) ............................................ 78

### Table 27. Number of abusive acts committed during the index offence, by group (percent, number) .... 78

### Table 28. Most intrusive sexual abuse, by group (percent) ............................................................................ 79

### Table 29. Severity of physical injury to victims, by group (percent) .......................................................... 80

### Table 30. Use of physical violence or threats to commit abuse, by group (percent) ...................................... 80

### Table 31. Severity of psychological injury to the victim, by group (percent) .................................................. 81

### Table 32. Acceptance of responsibility by offenders following treatment, by group (percent) ............... 81

### Table 33. Face-ups in treatment by group (percent) ......................................................................................... 82

### Table 34. Comparisons of groups before and after April, 1993 (percent, number) .................................. 83

### Table 35. Prior criminal and sexual offences before and after April, 1993 (percent, number) .................. 84

### Table 36. Official reports and convictions for prior offences before and after April, 1993 (percent, number) ........................................................................................................................................... 84

### Table 37. Recidivism rates from official reports and convictions 1989-2007, by group (percent) .......... 88

### Table 38. Recidivism rates from official reports and convictions (percent) by offence type and offender relationship to victim .......................................................................................................................... 89

### Table 39. Recidivism rates from official reports (percent) by age of youngest victim and group .......... 89

### Table 40. Overall, sexual and non-sexual reoffence rates 1989-2007, by group (percent, number) ............. 90

### Table 41. Overall, sexual and nonsexual recidivism before and after April, 1993 (percent, number) ....... 91

### Table 42. Reoffence rates by group before and after 1993 (percent, number) ........................................ 91

### Table 43. Sexual reoffences by program completers 1989-2007 .............................................................. 92

### Table 44. Average time to reoffend 1989-2007, by group (years) ............................................................ 94

### Table 45. Average time to reoffend 1993-2007, by group (years) ............................................................ 94

### Table 46. Offender relationship with victim and rate of recidivism (percent, number) ........................... 97

### Table 47. Number of victims of sexual recidivism, by group ................................................................. 97

### Table 48. Number of victims of sexual recidivism by biological and nonbiological fathers .................. 98

### Table 49. Number of overall, sexual and nonsexual reoffences, by group (mean) ................................. 99

### Table 50: Severity of index offences versus sexual reoffences, by group ............................................ 100
Table 51: Estimated reoffence rates (percent, number) and mean time to recidivate (years), by offence type and prior criminal history of offenders................................................................. 101
Table 52: Reoffence rates (percent, number) and time to recidivate (years), by STATIC-99 scores...... 103
Table 53: Acceptance of responsibility and recidivism rates (number, percent, and time to recidivate) 104
Table 54: Fleiss free-marginal kappa statistics for the 25 double coded case files................................. 246
Table 55: Intraclass correlation coefficients and 95% confidence interval, for the 25 double coded case files........................................................................................................................................ 247

LIST OF FIGURES

Figure 1. Annual number of referrals to the NSW Pre-Trial Diversion Program 1989-2007 ...................... 23
Figure 2. The NSW Pre-Trial Diversion of Offenders (Child Sexual Assault) Program Referral and Assessment Process............................................................................................................. 24
Figure 3. NSW Pre-Trial Diversion Program Referrals 1989-2003 ............................................................ 61
Figure 4. Offender age (mean years) at time of referral, by group ............................................................. 63
Figure 5. Self-reported history of childhood abuse in offenders (percent)............................................... 68
Figure 6. Reports of past criminal conduct by offence type and group (percent). .................................... 69
Figure 7. Prior convictions by offence type, by group (percent) ............................................................... 69
Figure 8. Static-99 scores by group (percent) ......................................................................................... 72
Figure 9. Offenders with more than one index victim, by group (percent) .............................................. 73
Figure 10. Intrusiveness of abuse by age of youngest victim. ................................................................. 79
Figure 11. Acceptance of responsibility by accepted offenders (percent) ............................................. 82
Figure 12. Victim and offender accounts of offending, by group (percent) ........................................... 83
Figure 13. Overall recidivism survival 1993-2007, in program completion groups ................................. 95
Figure 14. Overall recidivism survival 1993-2007, in declined and accepted groups ............................. 95
Figure 15. Sexual recidivism survival 1993-2007, in declined and accepted groups ............................ 96
Figure 16. Nonsexual recidivism survival 1993-2007, in declined and accepted groups ..................... 96
Figure 17. Overall recidivism survival 1989-2007, by offending history............................................... 102
Figure 18. Nonsexual recidivism survival 1989-2007, by offending history .......................................... 102
Figure 19. Overall recidivism by acceptance of responsibility for offending ........................................ 104
LIST OF APPENDICES

Appendix A: Information about Cedar Cottage for Offenders .......................................................... 130
Appendix B: Pre-Trial Diversion of Offenders Program Policy Document ........................................... 132
Appendix C: Sample Treatment Agreement .......................................................................................... 178
Appendix D: Orientation Information for Program Participants who have Sexually Abused Children .... 182
Appendix E: Response of the Board of Management of the NSW Pre-Trial Diversion of Offenders Programme (Child Sexual Assault) to the Evaluation Conducted by Professor Tony Vinson December 1991 – May 1992. .......................................................................................................................... 216
Appendix F: Protocol for Sex Offender Survey Project ......................................................................... 226
Appendix G: Family Reunification Coding Instrument .......................................................................... 238
Appendix H: Family Reunification Coding Instrument for Treatment Progress ..................................... 243
Appendix I: Expanded Disclosure Data Collection Sheet ..................................................................... 244
Appendix J: Results of Inter-rater Reliability Statistical Tests ................................................................. 246
Appendix K: Abstracts of Research Theses Related to the Evaluation Project ....................................... 248
The New South Wales Pre-Trial Diversion of Offenders (Child Sexual Assault) Program commenced operating in 1989 as a pilot program, known as Cedar Cottage. Four years later, in 1992, a qualitative evaluation of the pilot program was conducted by Professor Tony Vinson. One of his recommendations was the allocation of the sum of $35,000 for a quantitative evaluation of the effectiveness of the program to be conducted over a period of two years. Funds were not set aside for this purpose by Sydney West Area Health Service until 2005. This evaluation of the NSW Pre-Trial Diversion Program for Child Sexual Offenders was commissioned by the Sydney West Area Health Service to examine the program effectiveness, and commenced in 2006.

The project was accomplished with the cooperation and assistance of a large group of committed and talented individuals. An Advisory Reference Group offered support and guidance. Throughout the evaluation process, the researchers enjoyed the full support and cooperation of Dale Tolliday, Cedar Cottage Program Director, and other professional and administrative staff at Cedar Cottage, who opened their offices and files to the researchers.

Wayne Armstrong and his team from the NSW Police provided ongoing assistance in compiling reliable reports of criminal history data and convictions so we could develop a full profile of study offenders and create a more inclusive measure of recidivism. I am grateful to Don Weatherburn and other staff of the NSW Bureau of Crime Statistics and Research for their guidance and work in providing additional reoffending records to assist to refine the recidivism measures. Luke Grant, Caroline Ritchie and Simon Corben of the NSW Department of Corrective Services facilitated further refinements by specifying periods that offenders were incarcerated so the estimated lifetime recidivism rates were not inflated.

Data collection entailed manual audits of every clinical case file opened at Cedar Cottage since 1989, for treated and untreated offenders, to extract relevant information. This time-consuming and labour intensive process was completed by students in fulfilment of a research placement or internship experience that was established at Cedar Cottage so they could accrue credit for the M Psychol (Forensic) degree. Although the student interns and research assistants did not interact with offenders or victims, they often found the material in the files confronting and disturbing. I am appreciative of the oversight, counselling, support and education to these students provided by the clinical staff at Cedar Cottage, and Karen Parsons in particular, who ensured that the research process was accomplished without harm to the investigators.

One Honours student and seven M Psych (Forensic) students undertook research theses to test hypotheses and questions related to the evaluation. Copies of these eight theses are included as Appendices L through S to this report. The generosity of Dale Tolliday and his staff in facilitating the expansion of the project to incorporate additional student research was noteworthy, and speaks volumes about the willingness of the Director and the staff to subject their practices to scrutiny and disruption.

The contributions of several research assistants to the production of this report are gratefully acknowledged. Commitment to the project was exemplary in Jessica Pratley, who commenced as a placement student, went on to complete her M Psychol (Forensic) thesis on this topic, and after graduation, stayed on as the Project Manager. Her diligence in overseeing the database construction, liaising with multiple parties and drafting initial reports of Chapters 5 and 6 was invaluable. Reviews of literature for the first four chapters were advanced by the skills of Eva Cassedy, Remi Coker, Alana Krix,
Diana Matovic and Ben Walker. Amanda Mason assiduously cross-checked information and updated data files. Berenike Waubert de Puiseau compiled the draft glossary, methodically compared attributes of biological and nonbiological fathers and offenders before and after 1993, assembled appendices, consolidated tables and formatted the preliminary report. Kate O’Brien mastered the intricate interrater reliability analyses, conducted recidivism and other quantitative analyses for Chapters 6 and 7, updated tables and conformed the final evaluation document.

Thanks are due to consultants Professor Stephen Wong, Dr Mark Olver, whose experience with the coding instrument and analyses of risk and recidivism in sex offender populations was very helpful. Professor David Tait contributed his expertise with sentencing policies to frame the Executive Summary.

The evaluation provided an opportunity to describe as accurately and completely as possible the nature and scope of a controversial topic of considerable contemporary interest in the community, and to add to the knowledge of intrafamilial offending and adult sex offenders. Not being a provider of sex offender treatment, I approached the project task with no particular bias or interest in one form of treatment over another, and had no predispositions about the outcome.

The results are informative not only of the effectiveness of this particular community-based sex offender rehabilitation program, but contribute to the research literature on several aspects of intrafamilial and other sexual offending. This evaluation can assist in establishing a foundation for the development of future evidence-based policies in New South Wales to prevent child sexual abuse.

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GLOSSARY

Accepted group

Offenders who were accepted for treatment at Cedar Cottage following the assessment period comprised the Accepted group of study participants. From 1989 to 2003, a total of 93 male intrafamilial sex offenders were referred to and accepted for treatment at Cedar Cottage. This group was further divided into groups of offenders who completed the treatment program in two or three years, designated the Completed group, and groups of offenders who did not complete treatment, designated the Noncompleted group.

Assessment period

Upon referral to Cedar Cottage, offenders were assessed for their suitability for entry into the treatment program. The assessment period lasted up to four weeks from 1989 until April, 1993, and thereafter, up to eight weeks. During the assessment period, ideally, Cedar Cottage personnel meet with the offender individually at least eight times, and once in a group. Each day, the applicant offender must complete and submit written or voice-recorded assignments. The applicant must validate the account of the child victim and not limit himself to occurrences itemized in the criminal charges. These accounts must be made available to the nonoffending parent, either in person or in writing. Relevant family members are interviewed excluding the child victim.

Child sexual abuse

Child sexual abuse includes non-contact sexual conduct such as grooming and exposure, nonpenetrative sexual contact such as kissing and masturbation, and penetrative sexual contact. In this report, the term refers to conduct that meets the definitions of sexual assault offences classed as acts of indecency, indecent assault, and penetrative sexual assault in the New South Wales Crimes Act 1900.

Completed group

Offenders who were referred to Cedar Cottage and accepted into the program, and who went on to successfully complete the treatment program in either two or three years, comprised the Completed group. In this study the Completed group consisted of 53 male intrafamilial sex offenders.

Control group

Eligible intrafamilial sex offenders who were referred to Cedar Cottage but declined treatment served as the control group in this evaluation, and were compared to offenders in the group accepted for treatment.

Declined group

Offenders who were referred to Cedar Cottage and assessed for treatment but who were not accepted into the treatment program following the assessment period are referred to as the group declined treatment or the “Declined group”. The Declined group in this study was comprised of 121 male intrafamilial sex offenders.
Eligible offenders

Eligibility for treatment at Cedar Cottage was determined in two phases. First, the offender must be eligible for referral to Cedar Cottage and second, he must be accepted for treatment.

Eligibility for referral is based on seven criteria set by the NSW Director of Public Prosecutions:

- the child victim was under the age of 18 years when the matter was brought to Court;
- the offender is the child's parent, step-parent or parent's de facto spouse;
- no violence was involved in the act of sexual assault;
- the offender is over 18 years of age;
- the offender has no previous conviction for a sexual assault offence;
- the offender has not been offered the Treatment Program before; and
- there are available places in the treatment program.

The Director of the Treatment Program evaluates referred applicants using four clinical criteria:

- does the applicant accept responsibility for his behaviour;
- is the applicant aware of the significant impact of his behaviour on the victim and the victim’s family;
- does the applicant have sufficient communication skills to participate in the program, and
- is the applicant’s participation in the program in the best interest of the child?

Estimated lifetime recidivism rate

This term “estimated” refers to an aggregation of officially reported reoffences within a group of similarly-situated offenders. The aim was to estimate a very reliable but conservative rate of reoffending that approximated the actual reoffence rate, using official reports and records of convictions. To obtain the most accurate estimate, reoffence data from numerous sources were aggregated. The estimated lifetime recidivism rates reported in this evaluation are all derived from actual instances of reoffending reported to the New South Wales Police. Because not all lapses or reoffences occurred in New South Wales and not all reoffences that occurred in this state were reported to the New South Wales Police, the true rate of recidivism, which exceeds that reported in this evaluation, remains unknown.

Face-ups

A “face-up” is a full account by the offender of his abusive behaviour to a member of his family. The content of the account must validate the victim’s experience. Face-ups can match or extend the victim’s statement. Face-ups are delivered in writing or in-person to a significant family member. They are a key component of the Cedar Cottage treatment program.

Incest

Incest is the act of sexual intercourse between close family members. The New South Wales Crimes Act 1900, in Section 78A, defines a “close family member” as a parent, son, daughter, sibling (including a half-brother or half-sister), grandparent or grandchild, from birth.
Intrafamilial sex offender

Intrafamilial sex offenders are persons who engage in prohibited sexual conduct with close family members or persons with whom they have a familial relationship. In this study all the intrafamilial sex offenders were males who had a parenting relationship with a minor, whether or not the minor was a blood relative. The offenders in this evaluation were the child's parent, grandparent, step-parent or parent's de facto spouse.

Noncompleted group

Offenders who were referred to Cedar Cottage and accepted into the program, but who failed to complete the treatment program were designated the Noncompleted group. In this study, 40 offenders comprised the Noncompleted group. Noncompleters terminated the treatment program either because they breached the Treatment Agreement (n=32) and were involuntarily excluded from further treatment, or because they voluntarily withdrew from the treatment program (n=8). All noncompleters were referred to court for traditional sentencing after terminating treatment. To estimate the effect of treatment completion, this group was compared with the offenders in the group who completed treatment (Completed group).

Practical significance

This term refers to outcomes of the evaluation that have practical importance despite the fact that statistical tests and analyses may have failed to yield statistically significant results. Statistical significance is not the ultimate or sole determination of the impact of an intervention such as the Cedar Cottage treatment program. If a study is well-designed and multiple observations tend to converge to support the presence of the effect of the treatment, a nonsignificant trend may have important practical significance.

Relative reduction in recidivism

A relative reduction in a rate of recidivism is derived by comparing the observed absolute recidivism rate in the target group with that in the relevant untreated control group and computing the proportional reduction, if any, in the risk of recidivism in the target group following treatment. To calculate the relative reduction in recidivism, the difference between the two absolute recidivism rates is divided by the percentage of reoffending in the control group. For example, if 50% of the control group reoffend and 20% of the treated group reoffend, the relative reduction in the recidivism rate in the treated group is 60% or 50-20/50.

Reoffending data

To assess recidivism, reoffending data were gathered from multiple sources. Official reports of reoffending were compiled from the NSW Police Computerised Operational Policing System and the NSW Criminal Histories System database. Records of subsequent convictions were derived from the NSW Police and cross-checked against records in the NSW Bureau of Crime Statistics and Research Reoffending Database. To avoid inflating the survival period without reoffences following an offender’s last contact with Cedar Cottage, the Department of Corrective Services provided information about periods when the offenders were in custody and unavailable to reoffend. Although the focus of the evaluation was on sexual reoffending, records of other types of reoffending were also gathered and reported for comparative purposes.
Statistical power

Power in statistical terms is defined as the probability of detecting an effect given that the effect exists in the target population. The major factors that contribute to the power of an analysis are the sample size (N), the effect size, and the criterion or significance level (α = .05 or smaller). To assess the effects of treatment on recidivism in this evaluation, none of the study parameters could be varied (i.e., the sample size was determined by the number of referrals, the effect size was determined by the number of reoffences reported to the police, and the significance level in social scientific practice is set at 95%). Although this evaluation examined one of the largest samples of intrafamilial sex offenders studied to date, statistically speaking, the sample of offenders accepted for treatment was small. The effect sizes were also very small, as is typical in assessments of rehabilitation programs, particularly with respect to intrafamilial sexual offending. The base rate of sexual offending in this group was low, and the reoffence rate was lower, resulting in very low power. As a consequence, the probability of detecting an effect of treatment on recidivism was low.

Statistical significance

Statistical significance describes an outcome that is unlikely to have occurred by chance alone. A significant result does not necessarily imply a large or important practical difference. With a large sample size, even small differences produce statistically significant results that in practical terms may mean little or nothing. Conversely, the smaller the sample, the less likely a test is to render statistically significant results when a treatment effect is present. Factors that influence significance are similar to those contributing to power (i.e., sample size, significance level applied such as an alpha level smaller than .05, and effect size). Both statistical and practical significance (the implications of the results apart from statistical values) have to be considered.
EXECUTIVE SUMMARY

Children have a right to a safe family environment, to bodily integrity and to protection from violence, rights not only asserted by international conventions but endorsed by federal and state governments in Australia. One of the most serious violations of the right to a loving family environment is sexual abuse of a child by a person with responsibility for their care, in many cases a father or guardian. Incest can lead not only to disruption of families, but to ongoing trauma and lifetime suffering for the victims of such crimes.

One of the most innovative programs to address the cycle of sexual violence in families was developed by the Sydney West Area Health Service in 1989. Unlike many sex offender treatment programs, it applies a public health model to the care and protection of children. Known as the Cedar Cottage Pre-Trial Diversion Program, it provides therapy for sex offenders who plead guilty to sexually abusing a child in their care. Offenders referred to the program by the police or the courts receive an eight-week intensive assessment to decide if they will be accepted. Offenders then attend group and individual therapy sessions for a minimum of two and a maximum of three years. Meanwhile, victims and families, whose rights were central to the development of the program, are also provided with individual and group therapy sessions. The program is based on several key principles: giving primacy to the rights of victims, strengthening relationships between victims and nonoffending parents and siblings, and requiring offenders to take responsibility for their behaviour. Notably, family reunification is not a goal of the program.

This evaluation analysed the outcomes for 214 offenders referred to the program between 1989 and 2003, 93 of whom were accepted for treatment (p.61). After four years, in 1993 the program was reshaped based on the experience to date, with changes made both to assessment procedures and delivery of the therapy (pp. 20-21). All offenders in the study sample were men. Offenders ranged in age from 23 to 68 years, with a mean age at the time of referral of 39.5 years (p. 63). Most referrals (55%) were nonbiological fathers; 45% were biological parents (p.62). Charges ranged from non-contact offences such as exposure, to vaginal and anal penetration (p.76). Most offenders committed multiple acts against individual victims (94%), abused female victims (91%) and reported one victim (82%) (pp. 73-77). Offences were perpetrated against a total of 264 victims.

More than half of the referrals had a criminal history; 45% had a prior conviction. Approximately 11% of the referrals had some history of past sexual offending (p.71). Most past offences were for nonsexual, nonviolent offences (42%), although 15% of the referrals had been convicted of a violent offence. Individuals with convictions for violent sexual offences are ineligible for the program. The majority of offenders who had reports or convictions of prior offences had committed these offences during adulthood. Approximately one-fifth (20%) of the offenders started offending during adolescence and continued into adulthood.

Biological fathers tended to offend against younger victims and their offending continued for a longer period of time than that of nonbiological parents (p.75). Biological fathers were more likely to have more than one victim. Although biological fathers were significantly older than nonbiological fathers at the first incident of abuse (mean age: 38 vs. 35 years), biological fathers were significantly younger at the time of referral (mean age: 38 vs. 41 years) (p.63).
The average age of victims at the first incident of abuse was 8.5 years (p. 74) and the mean duration of offending was 3 years 2 months (p. 75). Victims were more likely to suffer psychological than physical injuries (pp. 80). Approximately 1 in 4 or 1 in 5 victims experienced sexual abuse accompanied by threats of violence or physical violence. Nonbiological fathers were significantly more likely to use threats of or actual violence than biological fathers (28% vs. 17%, respectively), but were no more likely to physically injure the victim than were biological fathers (p. 80).

Offenders who entered the program (n=93) were in almost every way identical to those who were declined treatment (n=121). They were similar in age, number of victims, duration of offending, number of charges, and history of childhood sexual abuse. Significantly more offenders accepted for treatment held full-time jobs (75%) than those declined (55%). However, because they were selected rather than randomly allocated to treatment and non-treatment groups it is possible that the two groups differed in other ways that are not easily quantified, such as willingness to accept treatment, genuineness of contrition or likelihood of benefiting from therapy.

Did the program work? Was the cycle of sexual violence broken, and the victims protected from future violence? The findings from this study are quite remarkable. The most comprehensive meta-analysis of the effect of criminal sanctions conducted by the Campbell Collaboration (an organisation founded to systematically review effects of interventions in order to improve policy and services) suggested that there was no difference in reoffending levels for more or less punitive interventions. Other studies of treatment options are relatively pessimistic about the possibilities of making long-term impacts on offending behaviour, particularly for seriously deviant offenders. Yet for the period 1989 to 2007, the Cedar Cottage Program produced a sharp drop in reoffending rates between individuals declined and those accepted for treatment (from 13.2% to 7.5%, respectively) for sexual offences—a reduction in the recidivism rate of more than two-fifths (p.90-91). Nonsexual offending in this period also declined in the group accepted for treatment, although not to the same extent. In making these estimates, we included with the program offenders those who were breached or those who chose to leave the program—almost half of those who entered treatment. This conservative procedure may underestimate some of the effects of the treatment program.

When we look into the figures in more detail, we see that the first four years of the program (1989-1993) did not seem to have any marked effect on offenders’ reconviction levels. The estimated lifetime reoffending rates for sexual offences was almost the same for those who entered the program (13.8%) as those who did not (14.9%). From 1993 to 2003 however, the program did seem to have a major impact. Those who did not enter the program had a reoffending rate for sexual offences of about 12%; those who participated in the program—even if they did not complete treatment—had a sexual reoffending rate of less than 5%. Given that the equivalent rate for the 1989-1992 cohorts was 14%, a recidivism rate under 5% is a success by any measure. A marked decline in recidivism for nonsexual offences was also observed from 1993 to 2003, a drop from 31% to 20% (p. 91).

Offenders who had not accepted full responsibility for their abusive behaviour at the point of their last contact with Cedar Cottage had higher recidivism rates and reoffended more often that those who did accept responsibility for their actions (pp.98-99). This finding demonstrates the importance of dynamic factors such as the acceptance of responsibility by the offender in a sentencing context as typically, the incentives in the legal system motivate offenders to persist in denial. Contact with the program substantially reduced the level of harm in terms of the number of victims and intrusiveness of offending (pp. 96). The proportion of non-contact sexual reoffences in the group accepted for treatment far
exceeded that among offenders declined treatment: 57% vs. 22%. Of 34 identified victims of reoffenders in the group declined treatment, 24 reported penetrative offences.

One possible explanation for the success of the program is that the treatment directly addresses deficits in self-regulation which current psychological research shows are centrally associated with sexual offending. Issues surrounding the delivery and efficacy of the treatment program were beyond the scope of this evaluation, thus the precise causes of the greater reduction in sexual and nonsexual recidivism rates observed after the 1993 legislative amendments are unclear. Whether they are the consequence of subtle fine-tuning in the delivery of the treatment as the program matured, or whether they are the result of more obvious differences such as the intensive eight-week assessment period adopted at that time, or due to staff changes or a host of other potential factors remains to be investigated in future research. What is clear is that the program dramatically reduced sexual reoffending after 1993. With relatively small numbers in the program, it is hard to be definitive, and to draw strong conclusions about what would happen if the program were applied to a larger number of offenders across New South Wales. There may also be some qualities of the program organisation and staff that cannot easily be replicated elsewhere.

A unique attribute of the pre-trial diversion program is the benefit to child complainants who are spared the burden and stress of testifying in legal proceedings. An additional advantage was the expanded disclosure of the scope of offending and the number of unknown victims that came to light in the course of treatment. This is an important benefit of offender treatment from the point of view of victims whose experiences of abuse had not previously been disclosed. When further offending is disclosed, Cedar Cottage staff ensure appropriate reports are made to the police, either by the offender who has disclosed the new information, or by a staff member. This disclosure by offenders validates the previously unknown victims’ experience, and provides an opportunity for victims to seek justice and treatment.

The incidence of intrafamilial sexual offending in the community remains a serious social problem and recent statistics indicate that both the number of offenders charged and the number convicted annually in New South Wales are increasing. The remarkably successful outcomes of this diversion program must be viewed in the context of other comparatively costly prison-based and community-based offender treatment programs, most of which are unable to demonstrate any effects of treatment. The outcomes of this program represent a very substantial reduction in costs to taxpayers compared to the costs of future police investigations, court processing and incarceration to punish reoffenders. Perhaps even more important to the future of the society is identifying the number of child victims whose lives are spared the trauma of sexual violation by a family member as a result of interventions like the Cedar Cottage Program. If the 10,000 child sex offenders reported in NSW from 1997 to 2006 had an expected recidivism rate of 12%, some 1200 children would be abused. However if these offenders underwent a program like the Cedar Cottage, the estimates produced from this study suggest that some 800 of these children would be spared this suffering.

In sum, this program is fully compatible with contemporary national and local initiatives implemented by the Council of Australian Governments (2009) by effectively preventing child sexual abuse and exploitation, by ensuring that survivors receive adequate support, by providing therapeutic and support services for families and children at risk of abuse, and by strengthening family relationships.
CHAPTER 1

OVERVIEW OF INTRAFAMILIAL CHILD SEXUAL OFFENDING

Definition of intrafamilial sexual offending ................................................................. 12
Previous research on intrafamilial sex offenders ....................................................... 12
The incidence and prevalence of child sexual abuse .................................................. 14
Child sexual abuse in New South Wales ................................................................. 15
Attrition between reporting and conviction ............................................................. 15
Summary .................................................................................................................. 17
CHAPTER 1

OVERVIEW OF INTRAFAMILIAL CHILD SEXUAL OFFENDING

Definition of intrafamilial sexual offending

Sexual contact between parents and children is prohibited in Australia. Throughout this report, the term “intrafamilial offender” refers to an adult who has sexually abused a child under the age of 16 years with whom he is in a parental relationship. The adult may be the child's parent, step-parent or a nonoffending parent's de facto spouse. In the New South Wales Crimes Act 1900, sexual assault offences are classified as acts of indecency, indecent assault, and penetrative sexual assault. The sexual conduct in issue falls broadly into three categories: non-contact or hands-off conduct, nonpenetrative contact, and penetrative contact. Examples of non-contact offences are peeping, exposure or exhibiting, and masturbation in front of a child. Nonpenetrative sexual contact includes fondling, kissing, and genital-to-genital contact. Penetrative offences include penetration that is oral, anal and vaginal, either penile, digital or with an object.

Background to the program evaluation

In 1989, the New South Wales Pre-Trial Diversion of Offenders (Child Sexual Assault) Act (1985) was implemented with the opening of Cedar Cottage to intrafamilial child sex offenders referred by the courts. As reflected in the program name, offenders who are diverted avoid the traditional criminal justice procedures associated with a trial. Cedar Cottage offers community-based treatment to sex offenders and their families. Unlike most other diversion and offender treatment programs in this state, the NSW Pre-Trial Diversion Program is administered by an interdepartmental Board of Advisors and reports to the NSW Minister of Health, not the NSW Department of Corrective Services.

This evaluation of the effectiveness of the Cedar Cottage Pre-Trial Diversion Program for intrafamilial child sex offenders was commissioned by the Sydney West Area Health Service to provide information to NSW policymakers on program outcomes, particularly the reoffending rates of persons referred to the program. Thus, the focus is on quantitative rather than qualitative outcomes. An assessment of the efficacy of the treatment process is beyond the scope of this report.

The majority of intrafamilial sex offenders are men. In the period evaluated in this report, all offenders referred the NSW Pre-Trial Diversion of Offenders (Child Sexual Assault) Program were men. Accordingly, for convenience, the male pronoun is used throughout this report when referring to child sexual offenders.

Previous research on intrafamilial sex offenders

Little reliable information is available about intrafamilial sex offending. In part this is because of the underreporting of the phenomenon. Another reason for the dearth of information on this topic is that among incarcerated sex offenders, from whom most data about sexual offending have been derived, few are intrafamilial offenders. Where research has been conducted on those populations, given that intrafamilial offenders comprise a small minority of offenders in penal institutions, sample sizes have generally been too small to make many generalisations about this sub-group of sex offenders.
Typically, the sample size of sex offenders included in institutional studies is modest. According to one recent meta-analysis which reviewed 69 reports of 80 different studies involving over 22,000 sex offenders treated in institutional settings, only 31% of the studies (n=25) included samples of more than 200 offenders (Lösel & Schmucker, 2005). Therefore, the present evaluation, with more than 200 offender participants, comprises one of the larger study samples of sex offenders in the empirical literature, and one of the largest samples of intrafamilial sex offenders internationally.

Studies that have explored the extent of similarities and differences between intrafamilial and extrafamilial offenders have produced mixed results. The exploratory nature of the questions addressed in several of these studies demonstrated that no definitive portrait of an intrafamilial sex offender exists, as is reflected in Table 1.

### Table 1. Studies comparing intrafamilial and extrafamilial child sex offenders

<table>
<thead>
<tr>
<th>Author</th>
<th>Date</th>
<th>Country</th>
<th>Community/Prison</th>
<th>N</th>
<th>Offence type</th>
<th>Recidivism</th>
<th>Trtd</th>
<th>Study purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firestone et al.</td>
<td>1999</td>
<td>Canada</td>
<td>Unstated</td>
<td>251</td>
<td>Contact</td>
<td>6.4% sexual</td>
<td>N</td>
<td>Identify recidivism risk factors</td>
</tr>
<tr>
<td>Greenberg, Da Silva &amp; Loh</td>
<td>2002</td>
<td>Australia</td>
<td>Western Australian Sex Offenders Treatment Unit</td>
<td>451</td>
<td>Contact</td>
<td>88.8% contact</td>
<td>7.02% untreated. 14.18% treated</td>
<td>N, Y</td>
</tr>
<tr>
<td>Rice &amp; Harris</td>
<td>2002</td>
<td>Canada</td>
<td>Mental Health Centre Penetanguishene</td>
<td>82</td>
<td>Contact</td>
<td>Not stated</td>
<td>Not stated</td>
<td>N</td>
</tr>
<tr>
<td>Mills, Anderson &amp; Kroner</td>
<td>2004</td>
<td>Canada</td>
<td>Ontario prisons</td>
<td>36</td>
<td>Not stated</td>
<td>Not stated</td>
<td>N</td>
<td>Compare antisocial attitudes of offenders</td>
</tr>
<tr>
<td>Eher &amp; Ross</td>
<td>2006</td>
<td>Austria</td>
<td>Austrian prisons</td>
<td>157</td>
<td>Contact</td>
<td>Not stated</td>
<td>N</td>
<td>Compare extra to Intrafamilial on criminal/clinical variables</td>
</tr>
<tr>
<td>Olver &amp; Wong</td>
<td>2006</td>
<td>Canada</td>
<td>Regional Psychiatric Centre (maximum security)</td>
<td>29</td>
<td>Not stated</td>
<td>46%</td>
<td>Y</td>
<td>Examine relationships between psychopathy, sexual deviance and recidivism</td>
</tr>
<tr>
<td>Studer &amp; Aylwin</td>
<td>2006</td>
<td>Canada</td>
<td>Alberta Hospital Edmonton</td>
<td>150 in study 1; 103 in study 2</td>
<td>Not stated</td>
<td>Not stated</td>
<td>Y</td>
<td>Examine whether incest offenders are low risk</td>
</tr>
</tbody>
</table>

Results of one of the comparisons between intrafamilial and extrafamilial sex offenders in a prison sample revealed that the former had less disturbed backgrounds and engaged in less antisocial and criminal conduct after reaching adulthood (Rice & Harris, 2002). Notably, no control for offender age was included in that study. A study measuring recidivism rates among “... men referred for psychiatric
assessment or treatment by the court, police, probation and parole services, defence lawyers, or other mental health professionals…” (Langevin et al., 2004, p. 536) revealed that intrafamilial offenders were in the oldest group, averaging 39.7 years of age, compared to the youngest group of sex offenders, who averaged 26.3 years of age. When age was taken into account in studies measuring antisocial attitudes and antisocial disorders, intrafamilial child sex offenders had similar rates of psychopathology to other sex offenders. A comparison within a group of federally incarcerated residents of treatment institutions in Ontario revealed that antisocial attitudes were not significantly different between intrafamilial child sex offenders and other sex offenders, after controlling for age (Mills, Anderson, & Kroner, 2004). Similarly, a comparison of incarcerated intrafamilial and extrafamilial sex offenders revealed no significant difference in the prevalence of antisocial disorders between the two groups (Eher & Ross, 2006). Overall, these results suggest that age differences may be an important factor distinguishing intrafamilial versus other sexual offenders, but it is less evident from the foregoing results whether intrafamilial offenders hold similar antisocial attitudes to other child molesters.

The incidence and prevalence of child sexual abuse

Currently, Australia lacks robust data on the incidence and prevalence of child sexual abuse (Council of Australian Governments, 2009). Thus, surprisingly little is known about intrafamilial child sexual abuse. A widely-endorsed myth is that children are primarily at risk from strangers (Kenny, 1997), but most sexual offences committed against children are perpetrated by family members and acquaintances (Gelb, 2007). Despite widespread concern over intra- and extrafamilial child sexual abuse, accurate estimates of its prevalence are hard to obtain. A substantial and persistent issue, acknowledged in law enforcement, is that sexual offending against children remains undetected and underreported (Morrison, 2007). The majority of these cases are never reported to police, resulting in a large gap between official numbers of sexual offending and the real numbers of offences (Gelb, 2007). Some researchers estimate that fewer than 30 per cent of all sexual assaults on children are reported, and that the reporting rate is even lower for Aboriginal and Torres Strait Islander children (Stanley, Tomison & Pocock 2003). This phenomenon arises for several reasons, primarily because the victims face daunting consequences when disclosing sexual abuse. In addition to the trauma they have experienced through the abuse itself, following disclosure they lose their anonymity, risk retribution by the offender, can experience stigmatisation, embarrassment or shame, and must participate in a burdensome legal process (Allen, 2007). Additional difficulties arise because children’s cognitive and developmental limitations often inhibit disclosure (Jensen, Gulbrandsen, Mossige, Reichelt & Tjersland, 2005). Children may find it difficult to initiate a conversation about something that has never been spoken of before, particularly where there are not many occasions for talking about such a topic (Jensen et al., 2005). Furthermore, children, especially when they are young, lack resources to make their own report to the police or other authorities (Hanson, Resnick, Saunders, Kilpatrick & Best, 1999). Instead, they must first inform a caretaker or another trusted adult whose responsibility it becomes to file an official report. If children report sexual abuse at all, a high percentage delays their disclosure, making prosecution of the offender more difficult (Terry & Tallon, nd; London, Bruck, Wright & Ceci, 2008).

An additional problem contributing to the underreporting of child sexual abuse is that victims are less likely to report to the police an offender who is known to them (Gelb, 2007). This factor is integral in intrafamilial child sexual abuse. Children may also view the perpetrator as an authority figure, may regard the sexual activity as an extension of this authority, and may be afraid of punishment or rejection after having disclosed (De Jong, Hervada & Emmett, 1983). Secrecy plays a considerable role in the upkeep of the abuse in families where intrafamilial abuse is occurring (Herman, 1981). Finally, social
isolation of the family makes detection of intrafamilial abuse less likely (Herman, 1981). Moreover, underreporting has been noted among professionals in whose care children are placed (e.g., non-abusing parent, doctors, and teachers) (Blaskett & Taylor, 2003; Kenny, 1997).

For various reasons, intrafamilial abuse comprises the most underreported group of all sexual offences (Reid, 1998). Estimates of the prevalence of intra- and extrafamilial adult/child sexual abuse range widely, from 0.6% to 62%. Estimates of the prevalence of intrafamilial child sex offences in the USA range from 5-15% (Forseth & Brown, 1981). In one sample of 930 adult women residents of San Francisco, who were interviewed by telephone, 42 (4.5%) reported at least one incident of intrafamilial sexual abuse before the age of 18 (Russell, 1984). Available statistics have to be considered conservative (Cossins, 1998; Gelb, 2007).

**Child sexual abuse in New South Wales**

The Australian Institute for Health and Welfare (AIHW) reported that as many as 41% of all sexual assault victims are under the age of 15 years (AIHW, 2009). For the period 1991-92 to 1995-96, there were 25,941 substantiated cases of child sexual abuse in the whole of Australia, the majority of which (61.6%; 15,968 cases) were reported in New South Wales. In 2003, the number of substantiated cases of child sexual abuse was 7500 (AIHW, 2009). A 30% increase in substantiated cases was observed between 2004-2005 and 2006-2007 (AIHW, 2009, vii). Most perpetrators were men, and female children comprised the vast majority of victims (75.2%; AIHW, 2009). In the four-year period, 2000-01 to 2002-03 and 2004-05, there were a total of 7,584 substantiated cases of child sexual abuse in NSW alone, with an average of 1,896 substantiated cases a year, according to AIHW. In New South Wales, Joint Investigation Response Teams (JIRT) with representatives from DoCS, NSW Police and NSW Health undertake official investigations of cases of child abuse that may constitute criminal offences. In the period 2007-2008, 3,000 cases were referred to JIRT (Council of Australian Governments, 2009).

**Attrition between reporting and conviction**

Data tracking the points at which attrition in the criminal justice process occurs in sexual assault cases come from a study conducted by the NSW Bureau of Crime Statistics and Research. In 2004, in NSW, the number of sexual offences reported to police exceeded the number of proven charges by approximately ten to one (Fitzgerald, 2006). Although this trend is evident with respect to sex offences against adult victims and child victims, the attrition in cases involving child victims is more extreme. Criminal proceedings were commenced in only 15% of the incidents involving child victims and in 19% of incidents involving adult victims. Eight percent of the incidents involving children and 10% involving adults were proven in court as a sexual offence. The major points of attrition lie between reporting and clear up, and then between clear up and the beginning of criminal proceedings. “Clear up” means that the police are no longer investigating, either because they have commenced criminal proceedings against a suspect or for another reason, such as withdrawal of the complaint (Fitzgerald, 2006).

In 2004, 3,752 child sexual offence incidents were reported to the police in NSW (Fitzgerald, 2006). Of these incidents, 1,042 (27.8%) were cleared up by the police within 180 days of reporting. In the NSW Local and Higher Courts 547 persons were charged with at least one child sex offence. Of these, 243 (44.4%) were found guilty of at least one child sex offence. Of all the persons found guilty, 138 (56.8%) received a sentence of full-time imprisonment and one received periodic detention. One thousand and fifty-seven individual charges of child sexual offences were finalised, of which 481 (45.5%) were proven. Whereas child sexual abuse cases constitute a significant proportion of all criminal trials (16% in the
Sydney District Court and 42% in regional District Courts) (Gallagher & Hickey, 1997), only approximately eight percent of all reported cases result in a conviction (Fitzgerald, 2006).

The rate of guilty pleas in child sexual assault cases increased between 2004 and 2006 according to BOCSAR (2008, Table 2). However, defendants are less likely to plead guilty to a sex offence compared to other offences and less likely to be found guilty at trial (Fitzgerald, 2006; Taylor, 2007). Accordingly, a steadily decreasing conviction rate of child sexual abuse compared to convictions for all other criminal offences combined was observed during the 1990s. More recent data confirm this trend, with the likelihood of conviction in the NSW higher courts for a child sex offence falling between one fifth and one quarter, where the accused pleads not guilty (Cashmore, 1995; Cossins, 1999).

In NSW, neither the police nor BOCSAR maintain data reflecting the number of intrafamilial child sex offenders charged each year (Tolliday, personal communication, 5 March 2008). In the absence of any systematic method to compile these data, no precise estimate of annual charge rates for intrafamilial offences can be provided. One consequence is that no information is available regarding the proportion of intrafamilial offenders charged who are referred to the NSW Pre-Trial Diversion Program. Another consequence is that the lack of information about the number of intrafamilial offenders charged makes it difficult to assess the extent to which individuals who are referred to the NSW Pre-Trial Offender Program are representative of or different from the larger cohort. As a result, little is known about intrafamilial sex offending in New South Wales.

The process of attrition of all sex offences in the criminal justice system is readily depicted by an inverted pyramid. Researchers have noted that sex offenders who move all the way through the criminal justice system represent only a very small proportion of all sex offenders (Gelb, 2007). Some information illustrative of this trend showing the outcome of charges and penalties of child sexual abuse cases in local and higher courts in NSW from 2004-2006 was compiled by BOCSAR (2008; Table 2).

The number of persons charged with child sexual offences has remained consistent in recent years, as shown by charges across the three-year period in issue. In 2007, the highest rate of recorded sexual assault in Australia was for female children between the ages of 10 and 14 years old (544 per 100,000 population; AIC 2008). The number of convictions is just under half the total number charged. While the proportion of intrafamilial offences in these groups is not specified, these data indicate no change in recent years in the substantial number of offenders in New South Wales eligible for referral to Cedar Cottage.
Table 2. Outcome of charges and penalties for child sexual offences in NSW courts 2004-2006

<table>
<thead>
<tr>
<th></th>
<th>2004 Local Court</th>
<th>2004 Higher Court</th>
<th>2005 Local Court</th>
<th>2005 Higher Court</th>
<th>2006 Local Court</th>
<th>2006 Higher Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons charged with at least one CSO</td>
<td>287</td>
<td>260</td>
<td>283</td>
<td>287</td>
<td>248</td>
<td>283</td>
</tr>
<tr>
<td>CSO charges heard</td>
<td>378</td>
<td>621</td>
<td>344</td>
<td>697</td>
<td>365</td>
<td>749</td>
</tr>
<tr>
<td>Persons convicted of CSO as principal offence*</td>
<td>83</td>
<td>144</td>
<td>74</td>
<td>166</td>
<td>92</td>
<td>170</td>
</tr>
<tr>
<td>Percent male</td>
<td>96.4</td>
<td>100.0</td>
<td>98.6</td>
<td>98.8</td>
<td>100.0</td>
<td>98.2</td>
</tr>
<tr>
<td>Percent female</td>
<td>3.6</td>
<td>0.0</td>
<td>1.4</td>
<td>1.2</td>
<td>0.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Principal Penalty**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Custody</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imprisonment</td>
<td>42.2</td>
<td>64.6</td>
<td>36.5</td>
<td>69.3</td>
<td>34.8</td>
<td>68.8</td>
</tr>
<tr>
<td>Detention in juvenile institution/Control order</td>
<td>0.0</td>
<td>2.1</td>
<td>0.0</td>
<td>1.2</td>
<td>0.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Periodic detention</td>
<td>0.0</td>
<td>0.7</td>
<td>1.4</td>
<td>0.6</td>
<td>1.1</td>
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</tr>
<tr>
<td>Community</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspended sentence with supervision</td>
<td>20.5</td>
<td>9.7</td>
<td>21.6</td>
<td>15.1</td>
<td>18.5</td>
<td>15.9</td>
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<td>7.6</td>
<td>6.8</td>
<td>0.6</td>
<td>9.8</td>
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<tr>
<td>Bond with supervision</td>
<td>14.5</td>
<td>5.6</td>
<td>13.5</td>
<td>3.6</td>
<td>15.2</td>
<td>4.1</td>
</tr>
<tr>
<td>Bond without supervision</td>
<td>8.4</td>
<td>2.8</td>
<td>14.9</td>
<td>1.2</td>
<td>14.1</td>
<td>1.8</td>
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<tr>
<td>Care and Treatment Order HC</td>
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<tr>
<td>Fine</td>
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<td>0.0</td>
<td>1.4</td>
<td>0.6</td>
<td>1.1</td>
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</tr>
<tr>
<td>Bond with no conviction</td>
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<td>0.0</td>
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<td>2.2</td>
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</tr>
<tr>
<td>No conviction recorded</td>
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<td>3.5</td>
<td>0.0</td>
<td>5.4</td>
<td>0.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Total N</td>
<td>83</td>
<td>144</td>
<td>74</td>
<td>166</td>
<td>92</td>
<td>170</td>
</tr>
</tbody>
</table>


* Principal offence is the offence charged which received the most serious penalty
** Principal penalty is the penalty, of all penalties imposed, which is the most serious

Summary

A comprehensive review of the literature on intrafamilial versus extrafamilial sexual offending is beyond the scope of this study, given its focus on treatment outcomes of one particular intervention program. However, one objective of this evaluation is to provide a detailed description of the demographic characteristics of the offenders, the index offences and offending characteristics to develop a more in-depth profile of the group of intrafamilial offenders referred to the NSW Pre-Trial Diversion Program. This profile may be helpful in delineating risk factors associated with intrafamilial offending, and consequently, in identifying effective preventive measures to increase the protection of children.
CHAPTER 2
THE NSW PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM
CEDAR COTTAGE

Establishment of the program.................................................................................................................. 19
1993 Legislative amendments.................................................................................................................. 20
Criteria for referral and admission........................................................................................................... 21
The treatment program............................................................................................................................ 26
1992 qualitative evaluation of Cedar Cottage.......................................................................................... 27
1992 recommendations for improvements ............................................................................................. 28
Summary .................................................................................................................................................. 31
CHAPTER 2

THE NSW PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM

CEDAR COTTAGE

Establishment of the program

Development of the legislation establishing the Cedar Cottage Treatment Program persisted for approximately five years, commencing in 1984 with the appointment of the New South Wales Child Sexual Assault Task Force. The Task Force was directed to investigate the “… social and legal responses to child sexual assault in New South Wales” and to recommend reforms to the government (Tolliday, 1991, p.23). Given the acknowledged difficulties in prosecuting intrafamilial child sex offenders in the traditional courts, one of the recommendations of the Task Force was the establishment of a tribunal to manage cases involving intrafamilial child sex offences outside of the criminal justice system (Laing, 1996; Tolliday, 1991). Opponents contended that a tribunal would lead to the decriminalisation of and a decrease in the perceived seriousness of child sexual assault offences (Laing, 1996). Ultimately, the Task Force rejected the proposed Tribunal and instead proposed a pre-trial diversion program, arguing that this program could undertake to rehabilitate offenders, protect their victims, and establish a more satisfactory way to deal with intrafamilial child sexual abuse than the traditional criminal justice system (Laing, 1996). Notably, the diversion is not a form of decriminalisation, but is an alternative form of prosecution in which the accused remains under the control of the criminal justice system, and traditional prosecution is resumed if the offender violates the diversion agreement (Vinson, 1992).

Broadly, the theory underpinning pre-trial diversion is that it can treat the behavioural problems that lead to criminal activity, whereas punishing the offender is not necessarily a deterrent to future criminal activity (American Bar Association, 1992, p.25, as cited by Tolliday, 1991). When a case undergoes pre-trial diversion, the case is moved “… out of the criminal courts to an alternate forum for mediation, arbitration or treatment…” (Tolliday, 1991, p. 16). The first documented formal pre-trial diversion program was established in 1965 in Flint, Michigan, with young offenders to prevent them from becoming involved in a criminal lifestyle (Tolliday, 1991).

On March 29, 1985, the New South Wales Child Sexual Assault Task Force presented a report to Premier Wran containing 65 recommendations. From this report, five legislative bills were drafted, including the Pre-Trial Diversion of Offenders Act 1985 (Tolliday, 1991). This act established the Cedar Cottage Pre-Trial Diversion Treatment Program (Laing, 1996; Tolliday, 1991). The stated purpose of the Act was “… to provide for the protection of children who have been victims of sexual assault by a parent or a parent’s spouse or de facto partner… ” and to establish a Department of Health-administered program, while stressing the importance of victims’ interests over the offenders’ interests (Pre-Trial Diversion of Offenders Act 1985 No 153, Part 1). A more detailed legislative history of the Act has been compiled by Tolliday (1991).

The main goal of the Diversion Program is 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 finally to stop child sexual assault offenders from repeating their offences” (New South Wales Legislative Assembly Hansard, 12 November 1985, p.9326).

The NSW Pre-Trial Diversion of Offenders Program (Child Sexual Assault) was established on the recommendation of the NSW Child Sexual Assault Task Force in 1985. In November 1985, the Pre-Trial Diversion of Offenders Act was passed with bipartisan support by the NSW Parliament. The legislation was not proclaimed until May 1989 (Response of the Board of Management, 1993). Thus, although the Pre-Trial Diversion of Offenders Act was adopted in NSW in 1985, implementation followed four years later, with the establishment of the Program at Cedar Cottage in Westmead in 1989.

Of significance to this report are some further amendments to the Act implemented in April 1993. These amendments were prompted in part by declination of treatment by the Director to two individuals who were referred to the diversion program. In the course of resolving the legal challenges surrounding their appeals of this decision, judicial interpretations emerged that the original intentions of the legislation were not all achieved by the 1985 Act. In introducing the amending legislation the Attorney-General, The Hon. J.P. Hannaford said:

“...As presently structured the program requires the participation of family members as well as the offender. It is clear from the context in which the legislation was (originally) passed that it was not the intention of Parliament to decriminalise or devalue the seriousness of the relevant offences against children,” (NSW Legislative Council Hansard, 18 November 1992, p. 67).

From 1989 until the legislative amendments in 1993, offenders who successfully completed the program were not formally convicted of child sexual assault. The absence of a conviction was regarded as an incentive for offenders to seek diversion. An offender who breached the program was returned to the referring court for processing through the criminal justice system. The Pre-Trial Diversion of Offenders Act amendments required the offender to plead guilty, and imposed a requirement that a conviction be recorded against the offender’s name as a condition of entry into the treatment program (Laing, 1996). This change was supported by program participants (D. Tolliday, personal communication, July 4, 2008).

**1993 Legislative amendments**

Significantly, the criteria and decision making procedures regarding eligibility and suitability of offender participants were also refined in the 1993 legislative amendments. A preamble to the Act, usually limited to civil legislation, was inserted to clarify that the Act was to provide for the protection of children, and that the best interests of the child were to prevail over those of the offender. The amendments also specified the inclusion of a range of sexual offences which had originally been omitted in apparent error, namely, sexual offences against male children by male perpetrators (Crimes Act 1900, ss78H, 78I, 78K, and 78L).

The New South Wales Minister for Health administers the Cedar Cottage Treatment Program and local administration is provided by the Sydney West Area Health Service. Funding is provided by the NSW Department of Health. An interdepartmental Advisory Body monitors its operation. The Advisory Board includes representatives from NSW Health, the Board of the Sydney West Area Health Service, The NSW Child Protection Council, the Minister of Community Services, The Commissioner of Police, the NSW Attorney General, and other relevant non-government agencies. These administrative arrangements were clarified at the time the legislation was amended in 1993. The program receives funding to support the Program Director, a Co-ordinator of Clinical Services, and four full-time Treatment Co-ordinators.
The 1993 legislative amendments clarified the matters which the Director of the Program can take into account when determining the suitability of an applicant, and the process for screening applicants was acknowledged as one of clinical discretion. The opportunity for persons assessed to appeal against a decision excluding them from diversion was limited to matters of procedural fairness. Outlining this, the Attorney-General said:

“In keeping with the philosophy of the Act, the bill will amend the Act to allow the director, in determining whether a person referred for assessment is suitable for participation in the treatment program, to take into account certain information held by government and other agencies and statements made by the family members of the person referred. The factors which the director will be able to consider in assessing suitability of a person referred....will include such things as the offender’s acceptance of responsibility for the sexual abuse of the victim and an ability to demonstrate some understanding of the impact of his behaviour on the victim and other family members. Whether the spouse or the de facto spouse of the offender is willing to participate as required by the director in the program will also be relevant. Also, participation in the program by the offender and his family must be in the best interests of the victim. As the assessment of the offender requires a clinical assessment of suitability, the director should be allowed a general discretion as to whether a person is suitable or not. The director will, however, be obliged to provide reasons for a negative assessment of an offender...” (NSW Legislative Council Hansard, 18 November 1992, p.68).

In light of amendments specifying the nature of factors to take into account to assess a person’s suitability for the treatment program, starting in April 1993, the period for assessment of individuals referred to the program was increased from four to eight weeks. The Cedar Cottage program incorporated a structured and intensive eight-week process to assess an offender’s suitability for treatment. Details of the referral and assessment process are set forth below.

Criteria for referral and admission

The process of referral of intrafamilial child sex offenders to the NSW Pre-Trial Diversion Program relies on the cooperation of the NSW Police, personnel at the Office of the Director of Public Prosecutions, and awareness of and understanding of the program by the offender’s solicitor.

Immediately after charging a person with an intrafamilial child sexual offence, the NSW Police have primary responsibility to provide the individual with information about the Cedar Cottage Treatment Program. This information is contained in a brochure describing the Program developed for use by the NSW Police. A copy of the brochure is included as Appendix A (Information About Cedar Cottage for Offenders). In essence the role of the police is to provide a copy of the brochure to persons charged with a child sexual offence if the offence appears to be intrafamilial. A definition of eligible intrafamilial offenders is included in the brochure, specifying that the treatment program is not restricted to persons who are biological parents, males, or who offend against female children.

In 1992, police awareness of the program was described as poor, and as a consequence, the brochure was not always offered, and dissemination of brochures and referrals were haphazard (Vinson, 1992). Concern was registered that the program was unable to achieve its capacity because of shortcomings in
this phase, and in addition, because lawyers may have advised their clients not to contact Cedar Cottage because of its newness and unpredictability (Vinson, 1992). Proposals were made to shift some of the responsibility for dissemination of information about the program to magistrates. Unfortunately, shortcomings regarding dissemination of information about the program and referrals to the Program have persisted. As is shown in Figure 1, the number of annual referrals who contacted the Program peaked in 1991 soon after the program commenced.

Upon receipt of the information brochure, responsibility shifts to the charged individual to decide whether or not to apply for assessment for suitability to participate in the Cedar Cottage Treatment Program. The role of offenders’ legal representatives in advising their clients whether to apply for diversion was not assessed in the course of this evaluation, as the Program Director lacks access to the identity of all individuals eligible for the program, and to eligible persons who do not apply.

Those individuals who wish to apply to the Diversion Program must indicate this desire in the Local Court prior to entering a plea of guilty. At this stage, the Court will grant an adjournment of up to four weeks to allow the NSW Director of Public Prosecutions (DPP) to conduct an assessment of eligibility. The seven eligibility requirements set forth by the DPP are:

- that the child victim(s) is under the age of 18 when the matter is first brought before the Court,
- that the person considered is the child’s parent, step-parent or parent’s de facto spouse,
- that there was no violence involved in the act of sexual assault,
- that the offender is over 18,
- that the offender does not have a previous conviction for a sexual assault offence,
- that the offender has not been offered the Treatment Program before, and
- that there are available places in the Treatment Program (Appendix B: Pre-Trial Diversion of Offenders Program Policy Document, Section 6, Prosecutor’s Guidelines).

An applicant deemed ineligible by the NSW DPP is returned to the Courts for the usual course of prosecution. If the DPP establishes that the applicant is eligible for the program, he is referred to the Treatment Program for a clinical assessment.

The Program Director has maintained records of the number of offender referrals received annually by Cedar Cottage for a clinical assessment. Since the amendment to the Act in 1993, written reasons for declination have been issued and no successful challenges have been brought to the decisions to accept or decline an offender referred for treatment. No one has been declined treatment on the basis that the program lacks the capacity to accommodate that individual. From 1989 to 2007 a total of 242 persons were referred to the Program. The adjudged capacity of the program is greater, i.e., up to 25 treated individuals and their families per year (Vinson, 1992). The referral rate average is 12-13 persons per year, but fewer than 10 persons per year have been referred since 2004. Not all referrals were accepted for treatment (see Figure 1). Accordingly, to date, the program has been substantially underused.

Observed fluctuations in the number of referrals annually, from a maximum of 26 persons in 1991 to a minimum of 5 persons in 2004, raise concerns that not every eligible person charged with an intrafamilial child sexual offence in NSW is provided information about the Cedar Cottage program by the police, thus limiting access to the program. Limited information about and access to the program is
a matter with implications for offenders, victims, their families and the community. The omission of persons eligible for treatment also weakens the potential for any evaluation to thoroughly examine the effectiveness of the program.

Figure 1. Annual number of referrals to the NSW Pre-Trial Diversion Program 1989-2007

![Graph showing annual number of referrals to the NSW Pre-Trial Diversion Program 1989-2007]

Once an offender elects to undertake a clinical assessment for eligibility to treatment at Cedar Cottage, the Court makes a further adjournment to the case for eight weeks for the applicant’s assessment. The Director of the Treatment Program applies four clinical criteria to determine whether an offender is admitted to the Program. These criteria, which are illustrative, not exhaustive, include the following considerations:

- Does the applicant accept responsibility for his behaviour;
- Is the applicant aware of the significant impact of his behaviour on the victim and the victim’s family;
- Does the applicant have sufficient communication skills to participate in the Program; and
- Is the applicant’s participation in the Program in the best interest of the child?

During the eight-week assessment period, the applicant attends a minimum of eight individual assessment sessions, one group session, and must complete and submit written (or voice-recorded if he has literacy problems) assignments which are prepared daily. Relevant family members are also interviewed with the exception of the child victim (as the matter at this stage is still pre-trial, and if not diverted, may proceed to trial in which the child will be required to give evidence). The applicant must validate the account of the child victim in this period, and not limit himself to concurrence with the charges, which are usually representative of a broader course of conduct. He must also meet with, or otherwise make available to the child’s nonoffending parent, a detailed account of his conduct. The nonoffending parent does not have to accept this; however the procedure is designed to establish ahead of formal diversion, a demonstration of responsibility, consistent with the aims of the Act.
Denial of the offending conduct to the investigating authorities does not preclude the referral of an applicant to the Program. The offender is not required to make admissions of guilt to the investigating authorities to proceed to diversion. Eligible persons, their legal representatives and police, have at times misunderstood these matters. Because some lawyers may not appreciate that their client does not receive a sentence upon entering a plea of guilty, they may advise their clients to refuse to plead guilty, thereby inhibiting the access to the treatment program of an eligible person (Tolliday, D., personal communication, 25 February, 2008).

Applicants who are assessed as unsuitable for the program are returned to the Courts to allow prosecution to resume. If the applicant is accepted into the treatment program, he must enter a guilty plea before the Local Court (Pre-Trial Diversion of Offenders Act 1985, Part 3, Procedure following giving of undertaking) and agree to remain in the program for a minimum of two years. Following this process in the Local Court, the matter is next heard in the District Court where the program participant is convicted of each of the offences with which he is charged, and he enters an undertaking to participate in the program and follow the “reasonable directions” of the Director. Some of these directions are set out in a Treatment Agreement which is signed by the offender and lodged with the Court (Laing, 1996). A sample Treatment Agreement is included in Appendix C. The referral and assessment process is depicted in Figure 2.

The offender must then move out of the “… residence where his victim and family reside, having no contact of any kind with the victim and other children in the family without the permission of the Program Director,” (Laing, 1996, p. 156). “If the person charged reverses a plea of guilt or fails to adhere to it, the Program is not available to them and they return for committal,” (Tolliday, 1991, p. 29). If the program participant breaches the Treatment Agreement, the Program reports him to the Court and the Court decides if he should return to the Court for further processing (Pre-Trial Diversion of Offenders Act 1985, s. 26). If the Court decides the breach is serious enough, the offender can be removed from the treatment program and, providing the plea of guilt is not reversed, proceed to sentencing for the charges of which he has been convicted (Tolliday, 1991). Program participants are free to withdraw from the program at any point, at which time they return to the courts for sentencing.

The Program Director estimates that in the years the program has been operating, an average of six family members have been treated alongside each offender. In the study period, all offenders referred to the program were men. Of this group 45.5% were accepted for treatment, 54.5% were declined (see Table 3). Since the program’s inception in 1989, 60 persons have completed the program, 33 have breached and 8 have withdrawn. The total number of offender clients treated by the end of 2007 is 110. Using an estimate of six family members per offender client, the total number of clients (offenders, families and victims) treated to date is 770. As time has passed, the proportion of offenders referred to the program who have been accepted for treatment has increased. For example, in the period 2004-2008, of the 29 referrals, 8 were declined, 20 or 69% were accepted (Tolliday, D., personal communication July 7, 2008).

**Figure 2. The NSW Pre-Trial Diversion of Offenders (Child Sexual Assault) Program Referral and Assessment Process**
Table 3. Number of offenders referred to Cedar Cottage 1989-2007, by group

<table>
<thead>
<tr>
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<th>1989-2007</th>
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</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>242</td>
</tr>
<tr>
<td>Declined</td>
<td>132</td>
</tr>
<tr>
<td>Accepted</td>
<td>110</td>
</tr>
<tr>
<td>Completed treatment</td>
<td>60</td>
</tr>
<tr>
<td>Breaches</td>
<td>33</td>
</tr>
<tr>
<td>Withdrawals</td>
<td>8</td>
</tr>
<tr>
<td>Currently in treatment</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Tolliday (1994)
The treatment program

Although the focus of the Diversion Program legislation is the protection and well-being of persons who suffer indirectly as a result of intrafamilial child sexual abuse (Vinson, 1992), a treatment program included in the Diversion Program was developed by a working party of the NSW Child Protection Council (CPC), and was known as the "special program" as defined by the Act. In 1989, the Cedar Cottage Treatment Program commenced treating eligible applicants in Westmead, Sydney as a pilot program (Laing, 1996). The treatment program is partly based on the ideas of Adelaide-based psychologist, Alan Jenkins (Tolliday, 1991; Laing, 1996). The central focus of Jenkins’ approach is that abusive men are responsible for their decisions, actions and consequences. Jenkins devised an “invitational approach” which provides a positive framework in which men can acknowledge their behaviour and address it (Jenkins, 1991). The Cedar Cottage Treatment Program uses a combination of evocative therapy, Cognitive Behavioural Therapy, and some education. No pharmacological treatment is offered, although a liaison psychiatry service is available for use when needed, and an active liaison with General Practitioners is maintained for all clients.

The Jenkins model incorporates a theory of restraint or self-regulation. A working assumption is that “all people have the capacity and inclination for respectful and nonabusive relationships. However, some people adopt ideas and beliefs which act as restraints on their pursuit of nonabusive and respectful lifestyles (Tolliday, 1991, p.13).

The aims of the program are three-fold (Response of the Advisory Board, 1993):

- To protect children.
- To prevent further child sexual assault in families where this has occurred.
- To increase responsible thinking and behaviour in offenders.

The treatment is aimed not only at offenders referred by the Director of Public Prosecutions, but also at other members of an offender’s family, to enable child victims to resolve the emotional and psychological concerns which arise from their victimisation; and to enable other family members, such as nonoffending parents and siblings of the child victims, to resolve the emotional and psychological concerns which have arisen for them as a result of the sexual victimisation within their family.

The Program stresses the importance of several factors, including the offender’s acceptance of responsibility for his offences, the safety of the child victim, helping re-create a bond between the mother and the child victim, and helping the mother build the strength to protect her child in the future (Laing, 1996). A central tenet of the Cedar Cottage treatment program, based on the work of Jenkins (1990; 1991) is that the traditional prosecution of sex offenders in the adversarial system encourages offenders to deny “the existence, extent or significance of the abuse” which causes the offender to avoid responsibility for his conduct and to place it on the child victim (Jenkins, 1991, p. 189). In Jenkins’ view, a key to the acceptance of responsibility by offenders is development of an understanding of the consequences of his conduct on members of his family. He advocated that courts should focus less on mitigating circumstances and victim impact, and more on assisting offenders to develop responsibility-based decision making. Family reunification is not a goal of the program.

Program participants are required to attend group therapy every two weeks and individual therapy every two weeks, on alternating weeks (Laing, 1996). The victims and their family members are offered
individual and, numbers allowing, group therapy sessions. The victim and other family members are assigned their own therapists, separate from the Program participant’s primary therapist.

The treatment program is divided into three phases: contemplating change, undertaking change and maintaining change. The time in each phase before transitioning to the next varies from one offender to another based on their unique circumstances. The treatment includes three key components:

- The offender is invited to “face-up” fully to his actions, and to provide a full account of his abusive behaviour. “Facing up” includes admitting to and outlining details of the sexual abuse to various members of the family (Laing, 1996). The information provided in a face-up must validate the victim’s experience. Facing up entails either preparing a document or meeting in person with the significant other, most typically the nonoffending parent. Thus, records are maintained of the extent to which an offender’s description of his conduct matches that of the victim, and changes in what he discloses as treatment progresses.

- The offender is asked to consider the position in which his conduct has placed the victim and others, and to begin making amends, where possible. To successfully complete Step Two, the offender must go beyond talking about his commitment to change and demonstrate this change.

- The offender must recruit an appropriate audience for his change, most typically persons closely associated with the offender, such as his immediate family members, close friends, parents, employers or employees.

In 1995, the “Cedar Cottage Orientation Information” was developed, outlining clear procedures and criteria for the timing of the Program participant’s treatment. This document specifies a precise timeline in which the offender is to complete the necessary steps of the Program (Laing, 1996). A copy of these guidelines is included as Appendix D (Orientation Information for Program Participants who have Sexually Abused Children). In addition to “face-ups,” the participant’s progress is reviewed regularly by staff and by the offender himself.

1992 qualitative evaluation of Cedar Cottage

In 1991, three years after the NSW Pre-Trial Diversion of Offenders Program became operational, the Program’s Advisory Board of Management commissioned Professor Tony Vinson of the UNSW School of Social Work to conduct an evaluation of the pilot program. The evaluation was conducted in compliance with a legislative requirement that the program be evaluated. The terms of reference of that evaluation included two major questions (Response of the Board of Management, 1993):

- How successful was the Pre-Trial Diversion Program during its pilot period?
- What improvements and efficiency might be achieved in the years ahead?

Evaluation data were gathered by means of approximately 50 interviews conducted in-person or via telephone: five victims of sexual abuse, seven nonoffending parents, nine offenders admitted to the program, one not admitted, six members of the Board of Management, a representative of the Office of the Director of Public Prosecutions, the Program Director, six professional program staff and other staff at Cedar Cottage, three professional workers in the field of child sex abuse. In addition case records, video and audio recordings of interviews were reviewed. The evaluation report was completed in
November, 1992 (Vinson, 1992). The evaluation addressed the success of the program and made recommendations for improvements.

Comments by participant offenders revealed the program was challenging and stressful, and the pressure to confront the reality of their deficiencies and to overcome them was intense. Clearly, participation was not an easy option compared to gaol. Interviews with offenders and their families revealed that profound and sustained changes resulted from their treatment in terms of improved relationships with their families, self-understanding and correction of behavioural patterns that led to offending. Vinson (1992) noted that the pilot program “appears to be most successful in achieving the goals established for it. Offenders are obliged to assume responsibility for their actions, the child victims of sexual abuse together with non-offending parents and family members, are being supported in their adjustment to a traumatic experience and assisted to reconstruct their lives on a more satisfying and self-determining basis” (p. 59).

In addition, this evaluation determined that growth of the program in the period 1989-1992 was slower than desirable, and that it was operating at about two-thirds of its capacity. The “benefits of such an apparently successful program could be made available to a larger number of abuse victims, their families and the perpetrators of abuse,” (Vinson, 1992, p.59). The core principles of the treatment program were found to be readily adaptable to other types of offenders and types of offences, thus were suitable for use in community corrections more broadly.

This evaluation included some analysis of the cost-effectiveness of the diversion program compared to costs of incarcerating the offenders, and rated the Cedar Cottage program very favourably on this dimension.

1992 recommendations for improvements

Included in the evaluation by Vinson (1992) were 16 recommendations for improvements. The evaluation was reviewed by the Program’s Board of Managers, and a formal response to the recommendations was lodged by the Board in January 1993. A full copy of the response of the Board of Management is appended to this report as Appendix E (Response of the Board of Management of the NSW Pre-Trial Diversion of Offenders Programme (Child Sexual Assault) to the Evaluation Conducted by Professor Tony Vinson December 1991 – May 1992). The recommendations and responsive comments by the Management Board are summarized in Table 4, as they comprise important historical background to the current evaluation. In all, nine of the 16 recommendations were endorsed (1, 2, 3, 7, 8, 11, 12, 14, and 16), a further three were partially endorsed (6, 10 and 15), one required further investigation (13), and three were not endorsed (4, 5 and 9). In particular, as elaborated below, Recommendation 5 led to a change in the organisational and management structure of Cedar Cottage.

Table 4. 1992 Evaluation recommendations and response

<table>
<thead>
<tr>
<th>No</th>
<th>Recommendation (Vinson, 1992)</th>
<th>Board of Management Response</th>
<th>Adopted*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Within six months of the tabling of this Review, a Charter of Service Standards should be developed by the Director and staff of Cedar Cottage and submitted to the Board of Management for its approval.</td>
<td>The development of a Charter of Service Standards is endorsed.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Written and videotaped case record material should not routinely be offered to the DPP when breach reports are furnished by the Director of the Diversion Program.</td>
<td>Endorsed in principle. However the programme is under a positive obligation to provide the Court with the fullest possible account of any breaches of undertaking.</td>
<td>Yes</td>
</tr>
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<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>3</td>
<td>Upon admission to the Diversion Program, offenders should be informed that it may be necessary for investigative staff to monitor their fulfilment of bail conditions, especially those relating to their non-contact with victims. Accordingly, a video recording of the offender should be made to facilitate his identification by investigative staff, should that become necessary.</td>
<td>Endorsed.</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Other than to attend emergencies, police and investigative staff should not enter the premises of the Diversion Program.</td>
<td>This recommendation is unduly restrictive. Police do enter the premises of the Programme for legitimate business, for instance, attendance at the Board meeting and other meetings. The overriding principle here is that the presence of such personnel must not intrude upon the clients and their therapy.</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>The Diversion Program should be administratively incorporated within the Western Sydney Area Health Service with the Director of the Diversion Program reporting directly to the Deputy Chief Executive Officer of the Area Health Service who should remain a member of the Advisory Board (see Recommendation 7). The Deputy CEO should oversee the administrative, financial and personnel arrangements within the Diversion Program. The Board should have responsibility for setting the broad policy, procedures and therapeutic direction of the Program, the shaping of its external relations and the development of any proposals regarding relevant legislation.</td>
<td>The recommendation to incorporate the PTDP within the Western Sydney Area Health Service (WSAHS) is not endorsed¹.</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Clients of the Program should be informed via the Program Brochure and by other means, that they can complain to a Deputy DEO of the Area Health Service if they have a grievance. When considering such a complaint, the Deputy CEO should be assisted by either of two independent therapist consultants nominated by the Advisory Board.</td>
<td>The proposed grievance procedure is considered inappropriate. The suggestion to inform clients better about the existing grievance procedure is considered appropriate. There should be further development of formal grievance procedures for clients in conjunction with the committee.</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>An Advisory Board should replace the existing Board of Management when the Diversion Program is administratively incorporated within the Department of Health. However, the same range of disciplinary and organisational interests should be represented on the Advisory Board which should continue to report to the Ministers of Health and Community Services and the Attorney-General</td>
<td>The organisational structure should be reviewed immediately as proposed in comments under Recommendation 5.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
on the efficiency and effectiveness of the scheme.

<table>
<thead>
<tr>
<th>Item</th>
<th>Proposal</th>
<th>Recommendation</th>
<th>Decision</th>
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</thead>
<tbody>
<tr>
<td>8</td>
<td>The brochure used to acquaint potential clients with the Diversion Program should be modified to explain the frequently onerous aspects of the Program mentioned by existing clients and outlined in the body of this report.</td>
<td>An information kit has been produced to explain the Programme in more detail to offenders, victims, their mothers and siblings.</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>Clinical staff should be encouraged to avoid the use of unnecessarily complicated language in their work with clients and clinical supervision should include discouragement of the use of jargon.</td>
<td>It is difficult to assess the extent to which therapeutic language is jargonistic. The recommendation implies that PTDP staff are not aware of such issues. This is not a justified criticism.</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>The first individual therapist to whom a sex abuse victim relates after entering the Diversion Program must be a female. Later transfer to a male therapist should only occur after careful consultation and with the agreement of the victim.</td>
<td>There is some clinical justification to support access by a female victim to a female therapist in the first instance. However, the availability of female therapists cannot be guaranteed and it must be left to the discretion and sensitivity of PTDP staff to make informed decisions in particular circumstances.</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>To help ensure stability of staffing, with resultant benefits for the therapy provided to victims, family members and offenders, staff gradings should be revised along the lines recommended in the body of the report.</td>
<td>The specialised nature of the clinical work being conducted needs to be recognised and staff gradings should reflect this.</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>An additional position of Research Assistant (estimated total cost of $35,000 p.a.) should be funded for two years to enable basic data to be compiled and evaluation studies commenced. During this pilot period applications should be made to sources of outside funding and links established with potential research collaborators.</td>
<td>Endorsed. Action to be taken when funds available.</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>A taxi voucher system be instituted to enable victims to attend Cedar Cottage and other nominated treatment centres. The vouchers to be allocated at the discretion of the Director (estimated annual cost $15,000).</td>
<td>The specifics of this proposal needs further investigation.</td>
<td>No</td>
</tr>
<tr>
<td>14</td>
<td>An approach should be made to the Chief Stipendiary Magistrate to gain the co-operation of Magistrates in drawing the attention of eligible offenders and their legal representatives to the Diversion Program.</td>
<td>Endorsed. The board will continue to facilitate appropriate awareness of the programme.</td>
<td>No</td>
</tr>
<tr>
<td>15</td>
<td>The Diversion Program should gradually be extended to areas of greatest demand throughout New South Wales, using qualified, appropriately prepared and continuously supervised professional staff.</td>
<td>The expansion of the PTDP throughout NSW to areas of greatest need would require extensive planning, consultation and obvious resource commitments. Such a move must take into account the complexities of such a proposal. The report does not adequately address in sufficient depth the implications of this proposal. It is a view of the Board of Management that resources be identified to employ a consultant to undertake a project.</td>
<td>No</td>
</tr>
</tbody>
</table>
16 Consultations should take place with the Ministry of Justice to enable the Director of the Diversion Program to assist community corrections officers to adapt and apply key principles of the Diversion Program to the field of community corrections.

Endorsed No

*Not all endorsed recommendations were adopted.

1 Discussions with the SWAHS suggest that while it would agree to the continuation of its financial and administrative role in the management of the PTDP, it would be inappropriate for it to accept any other policy related responsibilities. Successful operation of the Special Programme requires a management structure that:

- Ensures that the Special Programme fulfils the requirements of the legislation in both its corrective and treatment aspects.
- Facilitates co-operation between the relevant departments and agencies.
- Monitors the Programme’s operations.

A more satisfactory arrangement would involve the following: A NSW Department of Health PTDP advisory committee be established. The committee to be established by Ministerial appointment on a two yearly basis. Composition of the Committee: Chairperson: NSW Department of Health, Department of Community Services, Attorney General’s Department, NSW Police Service, Child Protection Council, WSAHS (Deputy CEO). The functions of the new Committee shall be:

- To formulate policy and monitor the operation of the Programme.
- To report annually to the Minister for Health, the Minister for Community Service and the Attorney General on the operation, efficiency and effective of the Special Programme in respect of its obligations under the Legislation.
- To contract the day to day administration of the Special Programme by the Department of Health to the Western Sydney Area Health Service.
- To select the Director and Deputy Director and ensure that appropriate performance appraisals are in place.

The Director is to act as executive officer to the advisory committee and attend and participate in all meetings and deliberations of the committee. The Director shall report to the chairperson of the committee. The Director shall be responsible to a senior officer of the WSAHS for the administration and financial management of the programme. The Responsibilities of the WSAHS are to include:

- Staff and personnel functions and associated administrative support.
- Financial reporting.
- Provision of and maintenance of the premises.
- Other as required.

Summary

The 1992 evaluation of the NSW Pre-Trial Diversion Program could not address the effectiveness of the treatment program by conducting any quantitative analyses as too few referrals had been made at that time to permit such an inquiry, and the available follow-up post-treatment period was too short to assess recidivism. A recommendation was made that the Diversion Program must be judged on the grounds of its effectiveness (Vinson, 1992, p.60), and the fact that there are direct benefits to the victim and other family members in addition to the offender. The focus of the current evaluation is the effectiveness of the Pre-Trial Diversion treatment program in reducing recidivism.
CHAPTER 3

COMMUNITY-BASED ADULT SEX OFFENDER TREATMENT PROGRAMS

The relevance of theories about intrafamilial sex offending ......................................................... 33
Community-based intrafamilial sex offender treatment programs ..................................................... 37
  United States community-based programs .................................................................................. 38
  New Zealand Community-based Programs ............................................................................... 38
Australian community-based programs ......................................................................................... 39
  New South Wales ....................................................................................................................... 39
  South Australia .......................................................................................................................... 39
  Western Australia ...................................................................................................................... 39
Summary ........................................................................................................................................... 41
CHAPTER 3

COMMUNITY-BASED ADULT SEX OFFENDER TREATMENT PROGRAMS

The relevance of theories about intrafamilial sex offending

The Cedar Cottage program commenced before much available literature on intrafamilial sex offenders was published, thus there was comparatively little to draw on by way of theoretical underpinnings. The typology of paedophiles as “fixated” or “regressed” first applied by Groth and Birnbaum (1978) classified sex offenders based on whether their primary sexual attraction was children (fixated) versus adults, who act out against children at times of stress (regressed). One premise underlying the Cedar Cottage legislation appears to be the presumption that intrafamilial sex offenders fall into the latter category, i.e., are regressed, not fixated, and therefore are lower risk and require less treatment than fixated offenders (Studer & Aylwin, 2006). Although the legislative history of the NSW Pre-Trial Diversion Program does not include explicit discussion of theories about sexual offending, the very nature of the community-based treatment program implied that the policymakers held the view that first-time incest offenders were amenable to treatment, more likely to admit their offending than others, and were unlikely to commit crimes other than intrafamilial sex offences.

Theories about the aetiology of incest can be important in guiding appropriate interventions (Stinson, Becker & Sales, 2008). In the time-frame that the NSW Pre-Trial Diversion Program commenced, four potential causal explanations for intrafamilial child sexual offending were distinguished: (a) individual deviance; (b) chaotic; (c) functional and (d) feminist (Haugaard, 1998).

Individual deviance proposed that the perpetrator was sexually deviant, i.e., sexually aroused by children. This theory draws on a four-factor model of paedophilia developed by Finkelhor (1986) that is still applied today (O'Reilly & Carr, 2004) in distinguishing three common clinical sub-types of child molesters: (i) Offenders with an exclusive and long-standing sexual and social preference for children (fixated); (ii) offenders who shift or regress from adult psychosexual adaptation, typically in response to stress (regressed); and (iii) offenders who are psychopaths or sociopaths with very poor socials kills and who turn to children because they are easy to exploit. However, more recent research has shown that social and interpersonal competence are independent of fixation (Prentky, Knight & Lee, 2008).

The chaotic theory proposed that disinhibition of taboos against incest occurs in certain circumstances, thus incest is situational or opportunistically motivated. The functional theory proposed that dysfunctional family systems were stabilised by incestuous relationships, e.g., to preserve family property. The feminist explanation was that men felt entitled to engage in abusive behaviour because of the dependent position of women in society. Varying interventions were proposed based on the causal explanations for incest.

Acknowledgment of the need for family support, whatever the theoretical orientation, was regarded as paramount and the importance of selecting legal and therapeutic interventions suited to the offender and family was emphasised (Haugaard, 1988). Where the family functional explanation was favoured, family therapy was proposed for all family members to modify dysfunctional family systems. By comparison, the feminist explanation did not favour family reunification and preferred incarceration over community-based treatment (Haugaard, 1988).
Sex offender treatment programs do not necessarily discriminate between intrafamilial and extrafamilial sex offenders. Guided by theories about the causes of sexual offending, three major types of sex offender treatment programs have emerged: biomedical, behavioural, and counselling. Biomedical approaches rely on surgical castration or pharmacological treatment, including hormonal medications such as anti-androgens or antidepressant drugs, to reduce sexual arousal. Behavioural approaches apply classical behavioural theory or cognitive-behavioural theories. The goal of the latter approach is to help the offender to recognise and interrupt his cycles of beliefs, fantasies, and rationalisations that include planning the offence. Counselling approaches include insight-oriented techniques, such as evocative therapy, to assist the offender understand his motives and to help the offender develop victim empathy. Psychoeducational counselling programs teach offenders about myths, relationships and management techniques.

In the years since Cedar Cottage was established, research has confirmed some causal theories of intrafamilial offending. For instance, “reports of father-daughter sexual abuse show that dominance over children or an emotional attraction and physical attraction to a child motivates many fathers,” (Giarretto, 1982; Haugaard & Samwel, 1992). However, several key questions about intrafamilial offenders remained unresolved.

One common perception of intrafamilial offenders is that they commit only intrafamilial offences when reoffending. Whether intrafamilial child sex offenders reoffend with a further intrafamilial child sex offence, an extrafamilial child sexual offence, or other types of crimes is important to consider in devising an appropriate intervention or treatment program. Some past research bears on this question. Recidivism rates were examined for 251 convicted male intrafamilial child sex offenders in Ottawa. After twelve years, 6.4% had committed a further sexual offence, 12.4% had committed a violent offence, and 26.7% had committed another criminal offence (Firestone et al., 1999). Additionally, among a group of convicted individuals receiving treatment at a hospital for having committed a sex offence against either a related or nonrelated child, 50% of the intrafamilial child sex offenders admitted during their treatment to previously having committed an extrafamilial sexual offence (Studer, Clelland, Aylwin, Reddon & Monro, 2000). Similarly, an evaluation of intrafamilial and extrafamilial child sex offenders in a treatment program in Arizona, USA, revealed that the majority of the intrafamilial offenders reported extrafamilial victims in addition to intrafamilial victims (Studer & Aylwin, 2006).

These results are not consistent with the perception that intrafamilial sex offenders commit only intrafamilial offences and raise a question about the extent of sexual deviance in intrafamilial offenders. Some studies conducted using prison samples have confirmed that intrafamilial sex offenders are less sexually deviant than offenders whose victims are exclusively extrafamilial. For instance, intrafamilial offenders in a Canadian prison sample were less likely to have vaginally penetrated their victims, and had lower recidivism rates than extrafamilial sex offenders (Rice & Harris, 2002). Conversely, other researchers argued that overcoming the taboo of incest requires more profound fixation than extrafamilial offending, thus intrafamilial offenders are more sexually deviant (Seto & Barbaree, 1999).

To explore this question, in the current study, the treatment files of the all offenders referred to Cedar Cottage were examined to determine the relationship between past offences, index offence, disclosure of other offences and reoffence rates. In addition, a comparison will be made of the index offences and reoffences to assess whether treatment is effective in reducing the severity of offending behaviours.

The question is whether the conduct and classifications presumed to differentiate intrafamilial from extrafamilial offenders are reliable. Several scholars have cautioned that reliance on index offences and
prior sexual offences is misplaced as these are poor indicators of deviant sexual behaviour. Data showing that many intrafamilial offenders have more than one victim have challenged the assumption that intrafamilial offenders are low risk. For example, more than half the intrafamilial offenders in a community treatment sample disclosed extrafamilial and nonbiological victims in addition to a biological victim, and only 37% of the intrafamilial offenders held a primary erotic preference for adults, while most held a preference for adolescent hebephilic victims (Studer & Aylwin, 2006). These findings support the view that intrafamilial sex offences are “simply a part of a larger overarching repertoire of deviant sexual behaviour,” (Studer & Aylwin, 2006, p. 6). To examine the extent to which intrafamilial offenders are “low risk” offenders, the current study will determine how many offenders referred to Cedar Cottage are “one off” offenders, i.e., committed abuse only on one occasion.

Current theories of sex offending focus on self-regulation deficits in offenders (Stinson, Becker & Sales, 2008; Ward & Hudson, 2000). Psychologists have distinguished four major categories of self-regulation: (a) emotion/mood regulation, (b) behavioural regulation, (c) cognitive regulation, and (d) interpersonal regulation. As individuals grow and mature, normal development includes the learning of appropriate and adaptive strategies by which to regulate oneself in these four domains. Some individuals do not develop in a typical way, and fail to internalise appropriate regulatory strategies. For example, the development of appropriate self-regulation strategies is disrupted in individuals who experience childhood abuse and neglect. To cope with the distress caused by the abuse or neglect, they rely on available external resources for self-regulation, primarily resources that do not require much effort and that provide immediate relief from distress. The particular types of external regulatory strategies that an individual will maintain or abandon are shaped largely by reinforcement contingencies and the extent to which the conduct is difficult or risky. A favoured external regulation strategy will persist when self-regulation is necessary to reduce distress or discomfort.

A central premise of this theory is that self-regulatory deficits predispose these individuals to a variety of behaviours. To cope with internal distress, sex offenders engage in diverse behaviours designed to increase their self-control and self-experience (Burk & Burkhart, 2003). These self-regulatory methods are maladaptive or dysfunctional and tend to include conduct that offers immediate gratification and requires minimal effort or short-term planning, such as substance use, antisocial or criminal behaviours, and sexual activity. For example, research findings indicate that sex offenders show relatively high rates of substance abuse and dependence. Estimates of illicit substance problems range from 60%-90% in adult sex-offender samples (Abracen, Looman, & Anderson, 2000; Becker, Stinson, Tromp, & Messer, 2003; Noffsinger & Resnick, 2000). Similar patterns have emerged with respect to nonsexual criminal activity: sex offenders reliably demonstrate a variety of nonsexual illegal behaviours (Simon, 1997a, 1997b, 2000) and many sex offenders commit nonsexual crimes first (Smallbone & Wortley, 2004). The multimodal model of self-regulation as it applies to the theory of sexual offending gives prominence to self-regulation deficits as a cause of deviant interests and behaviours. If this theory is accurate, then sex offenders, including intrafamilial sex offenders, may exhibit more deviant sexual interests than expected, may engage in more frequent deviant behaviours than expected, their rates of substance abuse will be high, and they may engage in other general (nonsexual) criminal activity.

A recently published study using a sample of sexually violent offenders treated in the community demonstrated a modest relationship between childhood experiences of abuse or neglect and dysregulation. More than three-quarters of the men in the sample (79%) reported historical use of illicit substances, and many reported a negative affect, and mood disorders. These individuals demonstrated poor self-control over their behavioural impulses. Path analysis provided some confirmation that
deficits in self-regulation led to affective instability which predicted sexual deviance and antisocial behaviour (Stinson, Becker & Sales, 2008). Further study of this theory was recommended using samples of individuals who have committed limited sexual offences but who have not developed entrenched patterns of paraphilia (Stinson, Becker & Sales, 2008). Because the offending behaviour is regarded an attempt to regulate the self and alleviate internal or interpersonal tension and stress (Stinson, Becker & Sales, 2008), treatment programs that focus on changing the established patterns of external self-regulation and on the development of internal self-regulation strategies in the four domains listed above, are well-suited to test this theory. Certain individuals referred to Cedar Cottage may comprise a suitable group for this purpose.

In brief, the recent development in the research literature indicating that intrafamilial sex offenders are not as low risk or benign as was previously assumed heightens interest in the outcomes of community-based intrafamilial treatment programs. If these offenders are similar to extrafamilial offenders and not as low risk as was hitherto presumed, effective treatment interventions for this group may have generalisable benefits applicable to extrafamilial sex offenders.

In the years that have passed since the NSW Pre-Trial Diversion Program was established, forensic researchers have compiled data on the outcomes of several sex offender treatment programs provided in gaols and in the community. Approximately one-third of sex offender treatment programs are community-based, for outpatients. Several programs are sex-offender specific, but relatively few treatment programs are specifically designed for intrafamilial sex offenders.

A recent literature review of outcome studies of community-based sex offender treatment programs (not limited to intrafamilial offenders), yielded a total of seven studies (Collins, Peters & Lennings, 2009). This review demonstrated that sample sizes were typically small (ranging from 35 to 202 offenders), with a follow-up period after treatment, where applicable, ranging from 1 to 11 years. Recidivism rates reported for the treated groups varied from 2-13%. In some studies, there was no comparison group, and in others, the method by which the rate was derived was unclear, thus the data were inadequate for a meta-analysis. Given the inconsistent results, the researchers concluded that while some community-based programs appeared to show potential in reducing recidivism, the data did not permit a conclusion that community-based treatment is effective for high risk offenders.

Whether the same conclusion applies to low risk sex offenders who receive treatment in a community-based setting has not yet been determined. Some community-based treatment programs comprise a form of aftercare and maintenance support following custodial treatment (Cumming & McGrath, 2000). Other sex offender treatment programs are established in the community to treat offenders who have not had prior treatment in custody and who have not been gaol. As such, these community-based programs are more comparable to Cedar Cottage.

Table 5 provides an overview of these studies.

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Table 5. Community-based adult sex offender treatment outcome studies

<table>
<thead>
<tr>
<th>Author</th>
<th>Date</th>
<th>Sample size</th>
<th>Follow up period</th>
<th>Recidivism outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marshall &amp; Barbaree</td>
<td>1988 &amp; 1991</td>
<td>68 completers; 58 noncompleters</td>
<td>1 to 11 years</td>
<td>13.2% completers; 34.5% noncompleters</td>
</tr>
<tr>
<td>(Canada)</td>
<td></td>
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<tr>
<td>Dwyer &amp; Mayer (USA)</td>
<td>1990</td>
<td>61 of 153, no comparison group</td>
<td>Used literature to gauge success</td>
<td>Claim significant improvement</td>
</tr>
<tr>
<td>Bingham &amp; Turner (USA)</td>
<td>1995</td>
<td>202</td>
<td>Mixed CBT treatment</td>
<td>2% recidivism claim, basis unclear</td>
</tr>
<tr>
<td>Procter (UK)</td>
<td>1996</td>
<td>54 completers vs. 54 supervised</td>
<td>5 year evaluation</td>
<td>5.5% treated; 16.7% supervised</td>
</tr>
<tr>
<td>Lee et al. (Victoria, Australia)</td>
<td>1996</td>
<td>35 completers; 23 noncompleters</td>
<td>1 year</td>
<td>8.1% completers; 12% overall</td>
</tr>
<tr>
<td>Lambie &amp; Stewart (NZ)</td>
<td>2003</td>
<td>79 completers; 5 noncompleters</td>
<td></td>
<td>7.2% completed; 16% control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>91 partial treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>181 probation for 5 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bates (UK)</td>
<td>2004</td>
<td>183 CBT; no comparison group</td>
<td>4 years</td>
<td>5.4% after four years.</td>
</tr>
</tbody>
</table>

Source: Collins, Peters & Lenning, 2009

Community-based intrafamilial sex offender treatment programs

Although few treatment programs are pre-trial diversion programs, and this fundamental difference may invalidate precise comparisons with Cedar Cottage, little is known about the effectiveness of community-based treatment interventions for this sub-group of sex offenders. Some of the major community-based treatment programs available for intrafamilial sex offenders are described below to explore the extent to which these programs establish any benchmarks relevant to the evaluation of the effectiveness of the Cedar Cottage treatment program. Key information about these programs is summarized in Table 6 at the end of this chapter.
United States community-based programs

Santa Clara Treatment Program
One well-known pre-trial diversion program for intrafamilial sex offenders is the Santa Clara County Treatment Program in California, which was started in 1971. The program is certified by the California Criminal Court as meeting mandated standards specified in the California Penal Code. Convicted child sex offenders are ordered to complete a minimum of one year in the Child Abuser’s Treatment Program. Since 1997, the program has been monitored by the Probation Department. Referrals are made by the court or the Probation Department.

Although no third-party evaluation of the program has ever been conducted, recidivism data spanning 20 years gathered by the program administrators themselves revealed rates of recidivism to be less than 2% for the 3000 people that received treatment in the program (Tolliday, 1991). No published report describing the evaluation method or results was located.

New Zealand Community-based Programs
Three independent community-based organisations provide treatment programs for adult sexual offenders who offend against children in New Zealand: Christchurch STOP, Wellington STOP, and SAFE Auckland. All provide treatment for both court mandated and non-mandated clients using a similar model of Cognitive Behavioural Therapy, with a strong emphasis on relapse prevention. The three programs apply similar group therapy components, including understanding how offending behaviour starts and is maintained, mood management, victim empathy, relationship skills, and relapse prevention. Similar individual components are offered, including arousal conditioning, individual therapy, family therapy (and support group) and systems or progress reviews (Lambie & Stewart, 2003).

Auckland SAFE
The SAFE Network, Incorporated has provided the SAFE Adult Program since 1992. It is the largest community-based sex offender treatment program in New Zealand (Lambie & Stewart, 2003). In 2003, over 70 adults and their families and over 90 adolescents and their families attended the program. Male and female clients are treated in a range of programs, which include a Maori program and a special stream for offenders with intellectual and learning disabilities (Lambie & Stewart, 2003). The SAFE team consists of clinical psychologists, social workers, psychotherapists and family therapists, some of whom are Maori staff.

Christchurch STOP
STOP Trust Christchurch has provided the Christchurch STOP program since 1989 (Lambie & Stewart, 2003). An assisted learning program for men with intellectual disabilities and learning difficulties is also offered. The programs are for men over the age of 19 years who have been involved in contact abuse (sexual contact with a child or non-consenting adult) and non-contact abuse (e.g., indecent exposure or viewing child pornography). The treatment providers include clinical psychologists, social workers, counselling staff, and Maori staff who work with Maori clients and their families (Lambie & Stewart, 2003).

Wellington STOP
Wellington STOP, Incorporated has provided the Wellington STOP program since 1993. It was renamed WellStop in 2005. Cognitive Behavioural Therapy is supported by action methods, drama therapy and a family systems approach to working with client’s families and other support networks. WellStop offers a specialised group program for Maori clients and their families conducted by Maori staff. Staff members
include psychologists, counsellors, therapists and social workers. Approximately 25 new referrals are made to the program annually (Lambie & Stewart, 2003).

**Evaluation of Christchurch, Wellington and Auckland programs**
An evaluation of the three programs assessed the effectiveness of treatment in reducing sexual recidivism amongst 175 court-mandated participants over the age of 19, who commenced treatment between January 1995 and December 2000 (Lambie & Stewart, 2003). Comparators who were not treated consisted of 28 court-mandated individuals with a history of child sexual offending and 186 child sexual offenders convicted during 1995 who received a prison or community-based sentence or probation. Demographic and offending patterns in the three groups were comparable. Using convictions as the indicators of recidivism, and a follow-up period of four years following treatment, assessment, or conviction, the rate of sexual reoffending was lowest among treatment completers (5.2%), 8.1% among noncompleters, 16% in the probation group, and highest (21%) in the assessment group. Nonsexual violent offending in the treatment group was 10% vs. 25% in the assessment group and 12% in the probation group. There were no significant differences in rates of sexual and non-sexual violent reoffending in the three treatment programs. Recidivism was unrelated to time in treatment or time since completion of treatment. Only 45% of the clients were deemed to have completed the program satisfactorily; and noncompletion was associated with higher rates of recidivism (Lambie & Stewart, 2003).

**Australian community-based programs**
Aside from Cedar Cottage, a number of community-based treatment programs for intrafamilial sex offenders operate in Australia. These are located in New South Wales, Southern Australia, and Western Australia.

**New South Wales**

*Pastoral Counselling Institute*
The Pastoral Counselling Institute was founded in New South Wales in 1995. The program accepts adult intrafamilial and extrafamilial sex offenders whose victims are children or adolescents. Individuals who have been incarcerated and who must be treated as a condition of probation or parole are accepted into the program and account for most of the referrals. Although most participants have been formally charged with criminal conduct, some self-referred participants have not. The treatment is provided by male facilitators with training in psychology and theology. The program uses a cognitive-behavioural therapeutic approach within a Christian theological framework. Treatment is provided in small and large groups.

The program’s effectiveness has not yet been formally evaluated (Collins, Peters, & Lennings, 2009). However, a recent study of a small group of participants compared treatment completers (n=18) and dropouts (n=15) to assess changes in dynamic risk factors. Following treatment, the proportion of participants assessed as low risk on the SONAR increased from 51 to 84% and a number of dynamic risk factors changed significantly (Collins, Peters, & Lennings, 2009).

**South Australia**

*Sex Offender Treatment and Assessment Program (SOTAP)*
SOTAP is a community based treatment program that has been operational in South Australia for over 15 years. SOTAP provides a psychologically based assessment and treatment service for adults who offend against children and young people. Clients may be mandated to participate, by order of a court
or the Parole Board, or they may participate on a voluntary basis. All child sex offenders in prison are assessed towards the last three months of their prison sentence to determine suitability for the program (Layton, 2002). In 2002, nearly 50% of the 147 ‘active’ clients in the program were self-referred.

Treatment at SOTAP requires a comprehensive assessment and understanding of a client’s family history, sexual development, offence history, current sexual behaviour and mental health issues, as well as the development of effective management of emotions and attitudes and empathy for the victim. Treatment is provided through an intensive cognitive-behavioural group therapy and individual treatment processes. An information and support group is also available for partners (nonoffending parent), family members and other support people (Layton, 2002). There are currently no published data on the effectiveness of the program.

Western Australia

SafeCare, Western Australia

SafeCare Inc, a community-based, not-for-profit, non-government organisation, was founded in 1989. Financial support was provided for 20 years by grants from successive state governments until 2009 when the current government withdrew public support to treat men who had abused or were at risk of abusing (Chamarette, personal communication November 4, 2009). In May, 2009, SafeCare closed.

In 2003, SafeCare reported dealing with 550 inframilial child sexual offenders and their families since 1989 (SafeCare, 2003). The clients were referred by the Department for Community Development, now the Department of Child Protection (DCP), or were self-referrals. The SafeCare Families Program was designed for families in which inframilial child sexual abuse by an adult had occurred or where a self-referral had concern that abuse is about to occur (Cant & Penter, 2006).

The Men’s Program consisted of four different modules (Cant & Penter, 2006) which focused on accepting responsibility, dealing with past trauma, developing victim empathy, and relapse prevention. In addition to their work with offenders, SafeCare offered programs for nonoffending parents, families, and child victims of sexual abuse and their siblings. The SafeCare Young People’s Program offered a family treatment program based in the community for the assessment, treatment, and long-term support of the child or adolescent sexual abuse victim, the adolescent offender, and members of their family (Grant, Thornton, Stevens, Chamarette & Halse, 2009).

In 2006, the SafeCare Families Program was independently evaluated by consultants hired by the DCP (Cant & Penter, 2006). According to the report, 89 men commenced the Men’s Program between January 1, 2003 and December 31, 2005. Of these, 76 (85.4%) completed the program. The evaluation was descriptive in its approach. No recidivism rates or inferential statistics were calculated. Instead, the evaluators met with the director of the program and coordinators of the Families Program. Telephone interviews were conducted with a number of DCP staff and city-based stakeholders, six perpetrators and two nonoffending parents. The number of interviewed offenders comprised fewer than 10% of all participants who entered the program during the evaluation period. The evaluation report did not specify whether the interviews were structured. Based on an analysis of the interviewee statements, a determination was made as to whether the criteria of the program were met. The evaluators concluded that “the program is child-focused, well-researched, well-documented and delivered by appropriately qualified staff” (Cant & Penter, 2006, p. 23). The report cited SafeCare estimates of the recidivism rate for the men in the Families Program to be just over 1%. However, no information was provided as to
how these numbers were derived. Because the evaluation of the SafeCare treatment program was
descriptive in nature and the investigators did not explain their methods for calculating recidivism rates,
it is difficult to draw conclusions from these data.

Table 6. Key features and outcomes of community-based treatment programs for adult sex offenders

<table>
<thead>
<tr>
<th>Program</th>
<th>Year commenced</th>
<th>Capacity</th>
<th>Intrafamilial or extrafamilial</th>
<th>Referral Source</th>
<th>Recidivism outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Clara Treatment Program</td>
<td>1971</td>
<td>3000 in 20 years</td>
<td>Intrafamilial</td>
<td>Pre-trial diversion</td>
<td>2%, no independent evaluation</td>
</tr>
<tr>
<td>Program California USA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SafeCare, Western Australia</td>
<td>1989-2009</td>
<td>550 in 15 years</td>
<td>Intrafamilial</td>
<td>Dept for Child Protection or self-referral</td>
<td>1% (Cant &amp; Penter, 2006)</td>
</tr>
<tr>
<td>STOP Christchurch New Zealand</td>
<td>1989</td>
<td>Unknown</td>
<td>Unspecified</td>
<td>Community probation or self-referral</td>
<td>5.6% (Lambie &amp; Stewart, 2003)</td>
</tr>
<tr>
<td>SAFE Auckland New Zealand</td>
<td>1992</td>
<td>Over 70 in 2003</td>
<td>Unspecified</td>
<td>Community probation or self-referral</td>
<td>8.3% (Lambie &amp; Stewart 2003)</td>
</tr>
<tr>
<td>WellStop, Wellington New Zealand</td>
<td>1993</td>
<td>25 referrals in 2003</td>
<td>Unspecified</td>
<td>Community probation or self-referral</td>
<td>9.4% (Lambie &amp; Stewart 2003)</td>
</tr>
<tr>
<td>Pastoral Counseling Institute New South Wales, AU</td>
<td>1995</td>
<td>Unknown</td>
<td>Both</td>
<td>Probation and parole personnel or self-referral</td>
<td>Unknown</td>
</tr>
<tr>
<td>SOTU Western Australia</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Both</td>
<td>Community or prison/parole release orders</td>
<td>No effect of treatment (Greenberg et al., 2002)</td>
</tr>
</tbody>
</table>

**Western Australia Sex Offender Treatment Unit (SOTU)**
The Western Australia Sex Offender Treatment Unit (SOTU) runs prison-based and community-based programs (Greenberg, Da Silva & Loh, 2002). The SOTU is not exclusively for intrafamilial child sex offenders, but for all sexual offenders. The programs are aimed at addressing the treatment needs of adult male sexual offenders, and reducing the risk of reoffending. Group therapy is the primary treatment mode, but the SOTU provides limited individual treatment to offenders who are not suited to the group therapy format. The community based programs are available to offenders who are either serving community or parole/prison release orders (Greenberg et al., 2002).

The Western Australian Attorney-General and the Department of Justice commissioned an evaluation of the SOTU which was conducted by the Forensic Psychiatric Unit of the UWA Department of Psychiatry with support from the University of Western Australia’s Crime Research Centre (Greenberg et al., 2002). The sample used for the evaluation comprised 2,165 offenders who were referred to the SOTU prior to October 2000. The offenders were on average 36.5 years old at the time of conviction. Intrafamilial
child sex offenders (biological or nonbiological parents) comprised 22.9% of the offenders referred. Intrafamilial child sex offenders were more likely to be older, to report childhood abuse, to commit contact offences, and to indicate that the index offence was premeditated. Their sentences were longer than those of extrafamilial child sex offenders. Inspection of the recidivism rates of the treated and untreated groups revealed no significant effect of treatment.

Summary

Little is known about the effectiveness of the foregoing community-based treatment programs for intrafamilial sex offenders. The need for additional research on community-based treatment programs in Australia for adult sexual offenders has been recognised (Macgregor, 2008). This evaluation assists in addressing that need. A recent meta-analysis comparing outcomes for sex offenders in cognitive-behavioural treatment programs showed they had a significant positive effect for many offenders, with the exception of intrafamilial child sex offenders. These researchers called for further research in the form of treatment evaluations on this specific subgroup of sex offenders to develop a solid empirical basis for differential indication (Lösel & Schmucker, 2005). The current evaluation of the NSW Pre-Trial Diversion program responds to this call.
CHAPTER 4
RECIDIVISM AS A MEASURE OF TREATMENT EFFECTIVENESS

The sample ............................................................................................................................................... 44
The indicator event to assess recidivism............................................................................................. 44
Incidence versus prevalence of reoffending ......................................................................................... 45
Reoffending databases ............................................................................................................................ 46
Base rates of sexual recidivism ............................................................................................................. 46
Length of the observation period .......................................................................................................... 47
Treatment and control groups .............................................................................................................. 48
Benchmarks to evaluate treatment effectiveness ................................................................................... 48
Random controlled trials ....................................................................................................................... 49
Treatment efficacy versus effectiveness ................................................................................................. 50
Interpreting sexual recidivism data ....................................................................................................... 50
Other measures of treatment effectiveness ........................................................................................... 52
Summary .................................................................................................................................................. 52
CHAPTER 4

RECIDIVISM AS A MEASURE OF TREATMENT EFFECTIVENESS

As noted above, underreporting and attrition in investigations and prosecution affect recidivism rates. Interpretation of an evaluation of a treatment program that uses recidivism rates as one measure of treatment effectiveness requires some appreciation of the way recidivism is measured and defined, which in turn has profound implications for the interpretation of the results (Gelb, 2007). Three key elements of recidivism are the sample, the indicator event and the observation period (Payne, 2007).

The sample

Research evaluations of sex offender treatment programs underscore the fact that sex offenders are not a homogenous group. The extent to which intrafamilial sex offenders are homogenous remains largely unknown, as few studies have examined intrafamilial offender treatment programs; these offenders are often assessed in institutional treatment programs along with other offenders. Undifferentiated reports make it difficult to predict average base rates of reoffending in intrafamilial sex offenders who are typically reported to be lower risk reoffenders than other sexual offenders (Lösel & Schmucker, 2005). A secondary complication of the fact that intrafamilial offenders may be lower risk offenders to start with is that treatment interventions are typically most successful with higher risk offender groups. Measuring treatment effectiveness in a group that is lower risk and moreover, a group that also has notably low reoffending base rates, poses a challenge.

The indicator event to assess recidivism

A critical element in assessments of the effectiveness of a treatment program is the measure of recidivism (the dependent variable). First, since the treatment is aimed primarily at reducing sexual reoffending behaviour, it is necessary to distinguish between types of recidivism, i.e., sexual versus nonsexual reoffending, and other general reoffending behaviours. A successful sexual offence treatment program may influence reoffending with regard to other criminal conduct, but not necessarily.

Next, the specific measure of reoffending conduct, whether sexual or nonsexual in nature, is important. Given the foregoing discussion about underreporting of sexual offences and the attrition rates between report and conviction, concerns about capturing data on reoffending are paramount. Studies that measure only convictions as the major indicator of reoffending miss valuable data on undetected recidivism (Langevin et al., 2004). Researchers have attempted to address the limitations of conviction data by including measures of lapse behaviours, breaches of apprehended violence orders which may indicate offending which is otherwise unreported, and reports of conduct and charges that may not be legally sufficient to sustain an indictment and prosecution. One study of Canadian sex offender recidivism starkly illustrated the difference in outcomes and measures of harm that are achieved using different indicators of recidivism: a comparison of official recorded recovictions with records of sexual abuse of a child gathered from police information and Children’s Aid Societies (unofficial records) revealed 2.4 failures (relapses or reoffences) in the unofficial records for every one recorded officially as a reconviction, and 2.7 times the number of victims were identified in unofficial versus official records (Marshall & Barbaree, 1988).
In order to compile data on reoffending, one must either rely on self-report measures or official administrative records, each method having its own advantages and disadvantages (Payne, 2007). Measures of self-report capture all offences which the offender is willing or able to admit, but lack reliability (Payne, 2007). Recidivism measures gathered using this technique lead to higher recidivism rates, although the problem of underreporting still exists, either because of a lack of willingness to report, an insufficient comprehension of the questions being asked in the self-report questionnaire, the absence of a common understanding of what behaviours are defined by law as criminal, or simply a poor memory for all events that occurred (Gelb, 2007; Payne, 2007).

With respect to the second criterion, the indicator event, police data and intelligence, as one form of official administrative records, contain information about apprehensions, charges or arrests (Payne, 2007). A further source of official records of reoffending is court data. Some studies dealing with the recidivism of sex offenders define recidivism as a reconviction for a sexual offence (Harris & Hanson, 2004). This measure of reconviction is the most conservative one, taking into account that detection rates of sexual abuse are quite low or that evidence might not be strong enough for sentencing (Gelb, 2007). All else being equal, the estimated recidivism rate should increase with each expansion of the definition of recidivism (Harris & Hanson, 2004). A meta-analysis of 61 studies of sex offender recidivism revealed that 43% of the studies used more than one data source for the indicator event (Hanson & Bussière, 1998). The most common sources were national criminal justice records, state or provincial records (both 41%), records from treatment programs (29%) and self-reports (25%). In one Canadian study, hospital records and legal data bases, among others, were used to calculate sex offenders’ estimated lifetime recidivism rates (Langevin et al., 2004).

One common method to estimate recidivism rates is to include all offenders ever charged with a new sexual offence (Harris & Hanson, 2004). On the one hand, reliance on data from police records underestimates offending, since not all incidents are reported to the police. On the other hand these data also overestimate offences (Payne, 2007), because these statistics very likely include people against whom charges are ultimately dropped, either because the alleged offending behaviour has not occurred or because the suspect is innocent (Gelb, 2007).

In the current study, to obtain the most accurate estimates of recidivism possible, reported reoffence rates were derived from multiple official data sources: NSW Police, NSW Bureau of Crime Statistics and Research, and NSW Department of Corrective Services. Both police records on reported reoffending behaviours and court data on convictions were compiled, permitting a comparison of rates of recidivism captured by these two indicators of reoffending. The term “estimated recidivism rate” emphasizes that the observed rates result from group aggregations-- there is no single definitive rate of recidivism. Consequently, lifetime recidivism rates, as they are commonly known, are the most precise attempt to measure recidivism.

**Incidence versus prevalence of reoffending**

When considering re-offence rates, it is important to distinguish incidence rates from prevalence rates. Often, recidivism data include only the total number of new charges that have occurred, that is, the total numbers of charges for all men in a given program. A single offender may be charged with multiple citations of child sexual abuse (for example inappropriate speech or touching) that may be recorded as several reoffences. This may convey an inflated impression of the scope of the recidivism. If the data report only the prevalence, or total number of persons who have reoffended, it is difficult to gain an in-depth understanding of how effective a treatment program is. Ideally, researchers should report both
incidence and prevalence rates of reoffending. In this study both incidence and prevalence reoffence rates are examined. However, because the state of New South Wales does not keep adequate records distinguishing intrafamilial from extrafamilial child sexual offences (Dale Tolliday, personal communication, 25 February, 2008) it is, difficult to access the true extent of incidence versus prevalence rates regarding recidivism of intrafamilial child sexual abuse.

**Reoffending databases**

One data source used in the present study is the Reoffending Database (ROD) maintained by the NSW Bureau of Crime Statistics and Research. This database, developed in 2001, links the court records of individuals convicted in New South Wales to determine rates of reoffending. ROD contains records of all finalised criminal court appearances in the Children’s, Local, District and Supreme Courts of NSW since 1994 (Hua & Fitzgerald, 2006).

Since there is no court-generated common identifier for offenders, the records obtained from different courts have to be matched using available information (Hua & Fitzgerald, 2006). During this matching process, errors can occur, aggravated by the fact that many records contain mistakes (e.g., spelling of names, variations in date of birth). Thus, it is not possible to achieve perfect matching; and both false negatives and false positives occur (Hua & Fitzgerald, 2006). False negatives (or missing records) occur when ROD fails to link two court records that actually belong to the same person. This leads to the finding of fewer entries (underestimation) than an offender has in reality. False positives (or false alarms), on the other hand, arise when ROD links two records that do not belong to the same person. This leads to the finding of more entries (overestimation) than an offender has in reality.

A recent simulation study investigated the rates of these two errors occurring in ROD (Hua & Fitzgerald, 2006). The rate of false positives was estimated at 0.057% meaning that for every 10,000 people in the database three were incorrectly matched to another person. The rate of false negatives was estimated at 6.2% meaning that for every 16 actual matches that exist in the data, one was not identified. Taking into account these findings, a miss seems more likely than a false alarm. This leads to potential underestimation of the number of conviction records for an individual, yielding an underestimation of recidivism.

A more significant limitation of ROD is that all records that are included in ROD are records derived exclusively from NSW courts. Individuals who reoffend in a different state, or different country, cannot be detected by inquiries directed to the NSW databases, leading to a further potential source of underestimation of recidivism.

**Base rates of sexual recidivism**

The base rate for sexual reoffending is lower that than for other types of crimes (Hanson & Bussiere, 1998), making it more difficult to obtain statistically significant outcomes when comparing base rates of sexual offenders with treatment and without treatment in the absence of very large samples. The problem of low base rates is that an analysis of available reoffending data that produces a nonsignificant result may mask the finding that the treatment program is effective in reducing offending behaviour. These obstacles are particularly extreme in the assessment of reoffending in intrafamilial sex offenders, a subgroup of the sex offender population in which even lower base rates of reoffending appear typical, and in which it is therefore more difficult to obtain large numbers in study samples. One problem in many previous evaluative studies is the failure to adequately discriminate between types of sexual offenders (rape, paedophilia, incest, etc.). As a consequence, the treatment implications for
various offender subgroups are confounded (Grant, Indermaur, Thornton, Stevens, Chamarette & Halse, 2009; Tomison & Poole, 2001).

**Length of the observation period**

In part, to address the problem of low base rates, some researchers have recommended a longer follow-up period following completion of the treatment program. The theory is that although reoffending is usually relatively swift for certain types of criminal offences, such as robbery, burglary, and violence, where sexual reoffending is concerned, because the reoffending rates even in the absence of any treatment are lower, more time is needed to capture the relevant reoffence data. For example, when reoffending rates of sex offenders were compared after a 5, 10 and 15-year interval following release from prison, the reoffence rates increased over time for sexual offences (Harris & Hanson, 2004). In another study, recidivism rates were compared after a 25-year period among six different types of sexual offenders who were referred by “the court, police, probation and parole services, defence lawyers, or other mental health professionals” (Langevin et al., 2004, p.536) for treatment of psychiatric assessment: (1) intrafamilial offenders, (2) genital exhibitionists, (3) extrafamilial child sexual abusers, (4) sexual aggressors of adult women, (5) miscellaneous offenders, and (6) persons who offended against both children and adults of both genders. At that point, measuring convictions, arrests and sex offences that were undetected by authorities, the intrafamilial sex offenders’ recidivism rates were not significantly different from the recidivism rates of the other sex offender groups (Langevin et al., 2004).

The length of the observation period also determines recidivism rates, with an increasing period leading to a higher cumulative number of recidivists (Harris & Hanson, 2004). Conversely, the probability that (criminal) behaviour will recur decreases the longer the offender has abstained from that behaviour. This means that the recidivism rate within the first two years is typically much higher than the rate ten to twelve years after the index offence has occurred (Harris & Hanson, 2004).

The preceding research underscores the fact that one weakness of many outcome studies is that recidivism is measured within too short a period following the index offence (Langevin et al., 2004). To report on treatment effectiveness, many published studies reveal an assessment conducted in only a 3-5 year time-frame following treatment (Lösel & Schmucker, 2005).

One disadvantage in waiting as long as 15 years to allow a sufficient follow-up period to conduct an evaluation of treatment effectiveness is that with the passage of more time, obtaining data to successfully match records becomes more difficult and more participant attrition occurs. Offenders may move out of the area in which they were treated, may change their address or name, and no longer appear in the relevant police database sourced to assess reoffending conduct. Thus, although a longer follow-up period is desirable, this feature is fraught with difficulties. An examination of published studies shows that incorporation of a follow-up period that exceeds seven years is rare. In this study, the observation period spanned 18 years, but varied among offenders: the minimum observation period was 3.78 years and the maximum was 17.96 years.

Methods to address differential periods of time after treatment among offenders have emerged. For example, early studies matched offenders to create parallel groups to obtain comparable reoffence data. Other techniques, such as survival analysis, obviate this need as the time since completion of the program can differ among offenders without compromising the capacity to detect whether the treatment is making a difference. Put another way, individuals who have and have not been treated can
be compared even if the period of time each has spent in the community following treatment or incarceration varies. In this evaluation, survival analysis was applied.

**Treatment and control groups**

A final consideration is the extent to which relevant and appropriate comparison groups can be constructed to permit a meaningful analysis of the effectiveness of an intervention or treatment program. A study that includes data only on the treated group does not provide the strength and quality of information regarding the program effectiveness of an evaluation of a treated compared to an untreated group. In this evaluation, the recidivism rates of treated and untreated groups were compared, i.e., recidivism rates of offenders referred to Cedar Cottage and accepted for treatment (Accepted Group) were compared with those of offenders referred to Cedar Cottage and declined treatment (Declined Group).

**Benchmarks to evaluate treatment effectiveness**

Approximately 20 years ago, a team of researchers conducting a meta-analysis of sex offending treatment programs concluded that there was insufficient empirical evidence to determine whether treatment was effective (Furby, Weinrott & Blackshaw, 1989). Ten years ago, a comprehensive review located only three studies in which random assignment to conduct controlled trials of treatment was used (White, Bradley, Ferriter, & Hatzipetrou, 1998).

The message to reviewers of evaluative results is to carefully assess the methodological strength of the research. To assist in this task, an international set of guidelines or standards is useful in designating criteria that distinguish more reliable approaches and permit causal inferences, i.e., permit the conclusion that the treatment, and not other factors, produced the measured or observed differences in the treatment group. These standards, known as the Maryland Scale of Scientific Rigor (Sherman et al., 1997), describe parameters to assess measurement validity and strength to determine causal relationships between treatment and outcomes (Lösel & Schmucker, 2005). As such, they provide some benchmarks of strong versus weak evaluations.

The Maryland Scale of Scientific Rigor (MSR) classifies methodological attributes of a study using a 5-point scale to rate features such as design (e.g., presence of control groups and type), sample size and statistical testing. The highest level (5) applies to random designs. Level 4 applies to studies in which randomised design is somewhat compromised or statistical controls or participant matching was used in order to assure group equivalence for comparative purposes. Level 3 applies to research in which group assignment may be incidental, but equivalence is demonstrated by measures on relevant variables. Level 2 is comprised of studies with non-equivalent control groups. Level 1 is the rating applied to uncontrolled studies. A recent meta-analysis of 69 studies involving 80 comparisons between treatment and control groups to assess treatment effectiveness (Lösel & Schmucker, 2005) revealed that the majority of studies (60%) attained Level 2 or less on the MSR, and a further 24% met the criteria for Level 3. Only 9% of the studies used matching groups or statistical control (Level 4) and 8% (6 studies out of 80) used randomisation. Thus, overall, only 40% of the studies had a sufficient control of treatment versus control groups to reach Level 3 or higher on the Maryland Scale of Scientific Rigor (Lösel & Schmucker, 2005). Approximately one-third of these studies were published since 2000, and two-thirds were North American. The current evaluation meets the criteria for classification at Level 3 of the MSR as offenders referred to Cedar Cottage were not randomly allocated to treatment versus no treatment groups.
Random controlled trials

In light of the above-mentioned frustration attributable to methodological inconsistencies and lack of rigour in evaluating treating programs, the American Association for the Treatment of Sexual Abusers (ATSA) placed increased emphasis on randomised controlled treatment studies (Hanson et al., 2002). Random Controlled Trials (RCTs) are generally considered to be the gold standard design for the evaluation of sex offender treatment outcomes (Marshall & Marshall, 2007). This research design has two features: the first is the random allocation of treatment volunteers to either a treatment group or a no-treatment group. This feature ensures that pre-selection criteria or biases in group composition do not impact interpretations of the effectiveness of the administered treatment. The second requirement is the implementation of strict procedures guaranteeing that the described treatment is precisely delivered to ensure treatment integrity.

One limitation of RCT is the fact that random allocation does not ensure that the resulting groups compared are perfectly matched, although researchers applying RCT assume that perfect matching is easily achieved thereby. Marshall and Marshall (2007) doubt whether a comparatively simple process such as random allocation can ever produce matched groups on the range of all factors that are relevant to address the research question (e.g., in the present study, recidivism rates of treated versus untreated intrafamilial child sex offenders). Furthermore, even if perfect matching were achieved, differences between groups would most likely arise due to the control group’s awareness that they were excluded from treatment, despite volunteering for it. As a result, the control group might develop feelings such as disappointment or anger. According to Marshall and Marshall (2007) the intention to match sexual offenders allocated to treatment or no-treatment groups will fail to take into account all possibly influential factors that could distort the appropriateness of the matching process. Thus, a matching groups design is not realistic, and is not as desirable as many researchers have considered it to be.

Furthermore, there might be a high refusal rate among sexual offenders to participate in a study when they are at risk of being allocated to a no-treatment group. A low participation rate diminishes the representativeness of the study, and thus the generalisability of the study outcomes. Finally, the likelihood is small that administrative or ethical approval to implement a study applying RCT will be granted, whereby treatment would deliberately be withheld from one group of the volunteering participants. Moreover, it cannot be expected that the public will tolerate that convicted sexual offenders are neither treated nor imprisoned, only to constitute a suitable control group for the treatment group in an evaluative research study.

A further shortcoming of RCT according to Marshall and Marshall (2007) is the requirement of strict adherence to a treatment manual. Citing the work of many researchers, Marshall and Marshall (2007) conclude that effective therapy requires flexibility, and the treatment provider to tailor treatment to the individual problems of the patients. Cedar Cottage allows a certain degree of flexibility during treatment. For example, treatment can be extended, if a participant requires treatment beyond the two year minimum.

Clearly, the group design applied in the current evaluation of the Cedar Cottage Program cannot meet the criteria of RCT, since courts and Cedar Cottage personnel did not randomly allocate the applicants to the treatment groups. By law, the courts assign applicants to the program. The staff members of Cedar Cottage have no influence on the nature or number of applicants they see for assessment. However, the question arises as to whether this is a problem for the evaluation of treatment effectiveness. Seligman and Levant (1998) argue that it is not, stating that there is little practical value to be gained from studies
that do not investigate therapy as it actually occurs in the field. As noted above, it is acceptable to perform an evaluation of a program which does not apply RCT, since the so called “gold standard” of RCT is unlikely to be achieved in practice.

Control group composition can be another indicator of methodological strength, as noted by the MSR. Approximately 24% of the studies included in the recent meta-analysis of sex offender treatment programs (Lösel & Schmucker, 2005) included a control group comprised of offenders who were declined treatment. The current study shares that feature and augments this literature.

More recent meta-analyses of sex offender treatment outcomes have included quasi-experimental studies in their analyses of treatment effectiveness (Lösel & Schmucker, 2005). In the absence of randomised controls, methodological strength is attained by comparing groups that are initially equivalent, or by using statistical methods to control for group differences. In the recent meta-analysis of 69 sex offender treatment programs conducted by Lösel and Schmucker (2005), initial group equivalence was demonstrated in only 25% of the studies, and statistical controls were applied in a further 6%. In most evaluative studies included in that meta-analysis, no information was available about the similarity of the treatment group and control group (36%). Thus, an important preliminary question in the evaluation of the NSW Pre-Trial Diversion Program is the degree to which the individuals referred to Cedar Cottage and accepted for treatment are similar or equivalent to those who are declined treatment.

Treatment efficacy versus effectiveness

In an evaluation of a treatment program, efficacy and effectiveness must be clearly differentiated. Efficacy refers to “the ability of an intervention to produce the desired beneficial effect in expert hands and under ideal circumstances” (Dorland, 1994; cited by O’Donnell, 2008, pp. 41-42). The purpose of the investigation of treatment efficacy is to show that the program can lead to desired outcomes under the most favourable conditions. The most favourable conditions are usually considered those which are equivalent to RCTs. If the program could not achieve desired outcomes under these conditions, this would “give evidence of theory failure, not implementation failure” (Raudenbush, 2007; cited by O’Donnell, 2008, p. 41).

Effectiveness, on the other hand, is “the ability of an intervention to produce the desired beneficial effect in actual use” (Dorland, 1994; cited by Dorland, 2008, p. 41). Usually, the evaluation of treatment effectiveness follows the evaluation of treatment efficacy (O’Donnell, 2008). It yields insight into the question as to whether the program achieves its outcome in actual clinical practice under more adverse conditions than the ones present under laboratory conditions.

The current evaluation of the Cedar Cottage Program assesses treatment effectiveness, since, as already outlined above, RCTs were not implemented. Furthermore, the treatment is evaluated as it is delivered in practice.

Interpreting sexual recidivism data

To determine the effectiveness of a treatment program, two methods of comparison are common. First, some researchers use the rate of sexual reoffending in the control group as a base rate of reoffending. A comparison is made of the absolute difference in percentage points between the sexual recidivism rates in the treated versus the control groups. The difference in percentage points is reported, and in some cases, an indication is provided whether that difference is statistically significant, and the overall effect
size is reported (Lösel & Schmucker, 2005). This strategy was used to report the effectiveness of treatment programs for adult sexual offenders in Australia and New Zealand, i.e., recidivism rates were compared in groups of program completers versus control groups comprised of persons who withdrew from the program and persons who received no treatment (Macgregor, 2008).

Meta-analyses have established that on average, offenders who attend rehabilitation programs have a 10% lower re-arrest, reconviction and re-incarceration rate than those who do not (Howells & Day, 1999). This figure comes from an examination of recidivism rates for all crimes, and is not representative of sexual reoffence rates (Losel, 1996). The average rate of sexual recidivism for treatment groups in a large meta-analysis of 22,000 offenders was 11.1% compared to a rate of 17.5% in a control group (Lösel & Schumacher, 2005), yielding a smaller difference than is typical for all types of offending. This difference of 6.4% represented a one-third reduction in the reoffence rate in the treatment group. In addition, treatment reduced the rate of overall recidivism in the treated group by 11 percentage points, also a one-third reduction in the re-offence rate. In other words, the treatment had an impact both on sexual and on overall reoffence rates. A reduction in violent recidivism of 5 percentage points between treated and untreated group represented a 44% reduction in the rate of recidivism following treatment. In all, 36% of the total sample was treated in the community as outpatients. Intrafamilial sex offenders comprised 22% of that study sample. In general, intrafamilial offenders were included in samples containing other types of sex offenders, and no studies were identified in which intrafamilial offenders comprised the entire study sample.

A reduction in reoffending rates is calculated by comparing the percentage of reoffending in the treatment group with that in the control group. The difference between these percentages is the absolute difference in reoffending. For example, the sexual recidivism rate yielded by one meta-analysis for treated offenders was 19% compared to 27% for untreated offenders (Hall 1995). The relative reduction in the reoffence rate of the treatment group is calculated by dividing the difference in reoffending by the percentage of reoffending in the control group (Farrington & Welsh, 2005). For example, “if 50% of the control group reoffended and 20% of the [treatment] group reoffended, the percentage decrease [in reoffending in the treatment group] would be 60% [(50-20)/50]” (Farrington & Welsh, 2005, p.5).

As had already been demonstrated in earlier studies (Schweitzer & Dwyer, 2003), recidivism rates for higher risk offenders were more dramatically reduced than recidivism rates for lower risk offenders. Results indicated that treatment was usually more effective on higher than lower risk groups, because the base rate of reoffending is already low in the lower risk groups. This meta-analysis produced a relatively large effect size for rapists, and significant effects of treatment for other types of sex offenders. Notably, the only specific offender group in which no treatment effects emerged was the group of intrafamilial sex offenders. The researchers attributed this outcome to the low recidivism base rate in intrafamilial sex offenders (Lösel & Schmucker, 2005). It is not uncommon to achieve a nonsignificant effect, even if the recidivism rate has practical significance, i.e., the rate in the treated group is lower than that in the control group by several percentage points. This review indicates that despite the presence of a number of methodological strengths in the present evaluation, statistically significant effects as a result of treatment will be difficult to attain using recidivism rates as an outcome measure. In this study, the observed recidivism rates of the groups accepted for and declined treatment are compared to determine absolute differences in the reoffence rates and also the relative reduction in the reoffence rate, if any is observed, in the group accepted for treatment.
A further method of assessment is to compare the recidivism rates observed in the groups accepted for and declined treatment with the expected recidivism rates in the same groups as predicted by a reputable risk assessment tool, such as the STATIC-99 (Hoy & Bright, 2009; Macgregor, 2008). In the current evaluation sample, retrospectively applied STATIC-99 scores were uniformly too low (see Chapter 6, Figure 8) precluding effective application of risk-band analyses.

**Other measures of treatment effectiveness**

Although the focus in this evaluation is on recidivism, additional inquiries about harm-reduction were examined as relevant indicators of treatment effectiveness. A comparison of outcomes in the groups accepted and declined treatment assessed several additional indicators including (a) the length of time spent in the community before relapse; (b) the number of victims affected by reoffenders; (c) the number of reoffending incidents committed by recidivists; and (d) any reduction in the degree of intrusiveness in sexual reoffending (Marshall & McGuire, 2003). The current study examined these additional indicators to take into account the extent to which the treatment program offered at Cedar Cottage reduces harm to victims.

**Summary**

To assess the effectiveness of the Cedar Cottage Treatment program in reducing recidivism, a determination was made to include in the study sample all offenders referred to the program in a 14-year period, 1989-2003. Two indicator events to measure recidivism rates were selected: The first, official police intelligence and reports or reoffending, allowed more extensive insight into relapses than did the second, official reconviction records. The observation period varied depending on the year that an offender was last in contact with the Cedar Cottage program. The evaluation period selected in which to assess reoffending conduct extended from 1989 through the end of 2007, allowing the most recent referrals an observation period of up to four years after their last contact with Cedar Cottage. Other measures devised to assess other indications of harm reduction to victims were included where feasible.
CHAPTER 5

METHOD AND PROCEDURES

Research questions .................................................................................................................................. 54
Research design ........................................................................................................................................ 54
Procedure ................................................................................................................................................. 54
  Ethical approval ................................................................................................................................... 54
  Data collection .................................................................................................................................... 55
  Interrater reliability ............................................................................................................................. 56
  Criminal records .................................................................................................................................. 57
Summary .................................................................................................................................................. 59
CHAPTER 5
METHOD AND PROCEDURES

Research questions

This evaluation addresses the following questions:

- Does the treatment program reduce the recidivism rate of intrafamilial sex offenders?
- What is the nature of any differences between program completers, noncompleters and unsuitable groups in recidivism rates, survival times, and reoffence types?
- Are there differences in recidivism rates of biological versus nonbiological offending parents?
- Are there differences in the disclosure of treatment completers versus noncompleters regarding the acknowledgement of sexual abuse and related activities in the context of their families?
- What are the outcomes for victims associated with the program?

Research design

Participants were individuals referred to Cedar Cottage from the date of its inception in 1989 until 2003. The 2003 cut-off date was chosen to allow the most recently-referred cohort of offenders a follow-up period of approximately four years within the community after their final contact with Cedar Cottage regardless of treatment status. A quasi-experimental research design was applied in which two major groups were distinguished amongst persons referred to the program in the 14-year period 1989-2003.

The offenders were divided into two groups based on whether they were accepted for treatment in the program or declined. In all the analyses, including recidivism measures, the group declined treatment served as a control group for those who were accepted into the treatment program. Individuals accepted into the program were further classified into one of three sub-groups: (i) offenders who completed treatment and offenders who were excluded from the treatment program prior to completion either because they (ii) breached their Treatment Agreement or because they (iii) voluntarily withdrew from the program prior to completion.

Procedure

Ethical approval

Permission to conduct the evaluative study using archival records was obtained from Sydney West Area Health Services [JH/TG HREC2006/12/4.23(2485)], the University of New South Wales Human Research Ethics Committee (063155), and the NSW Department of Corrective Services (06/5181). Approval from each ethics committee was conditional upon maintaining participant confidentiality. Appropriate procedures were established to ensure participant privacy. All data used in the evaluation were gathered from official records maintained in the regular course of business by Cedar Cottage personnel, the NSW Police and the NSW Department of Corrective Services.
Data collection
Case files for each participant were systematically audited and data for 118 variables were recorded on a coding instrument developed and adapted for this purpose by the project consultant and the Program Director (Appendix F, Protocol for Sex Offender Survey Project). The coding instrument included items to compile retrospective risk assessment scores about the offenders using standard psychometric instrument indicators such as the STATIC-99 (Harris, Phenix, Hanson & Thornton, 2003), and The Sex Offender Need Assessment Rating (SONAR) (Hanson & Harris, 2001) (see Appendix K). Five sections of the coding instrument were distinguished.

Section One recorded basic demographic information (date of birth, suburb where abuse occurred, date of referral, etc.) and information about the offender’s developmental history and life skills: their experiences of physical, emotional or sexual abuse before the age of 16, intellectual functioning, current or past psychotic or affective disorder, employment history, social skills, and substance abuse and its relationship to the sexually abusive conduct was scored. The latter items were rated on a scale which ranged from 0 (no history) to 2 (presence of difficulties in the area of interest). For each item, there was an option to note “insufficient information”.

Section Two documented the offenders’ criminal and violent history, the types of offences previously committed, whether aggressive towards animals or objects, and a history of violence against partners. Sexual offences were coded to capture any sexual violence, and the range of offences committed (e.g., indecent assault, sexual touching, sexual harassment, sexual assault), and the type of victim (adults, children, both).

Information Sections One and Two was derived primarily from pre-referral sources and records gathered during assessment interviews. Pre-referral sources included police interviews, letters from professionals (psychiatrists, psychologists or doctors), and communications with nonoffending parents. After June 1995, applicants completed a Psychosexual Life History form (Nichols & Molinder, 2008) prior to their first appointment at Cedar Cottage. This form obtains a chronological history of the applicant’s life, and addresses health, personality, parental and family history, developmental history, education and employment history, substance abuse, childhood, adolescent and adult behavioural history, and sexual development and relationship history. The form included space for applicants to describe the index offence for which they were referred to Cedar Cottage.

Section Three of the coding instrument recorded the index offence/s, the number of incidents of abuse, the frequency and duration of offending, and number of charges the offender was facing at the time of referral. Disclosures by the offenders made at the time of referral, assessment and in treatment about other offending behaviour (sexual and nonsexual) in which they had engaged, were recorded. The degree of sexual contact was coded (no contact, sexual touching, penetration, or insufficient information), as was the type of sexually abusive behaviour attempted or completed, the degree of planning or premeditation leading to the offence, and whether threats, physical violence, or weapons were utilised. The offenders’ self-reported reasons for the abuse were noted (e.g., jealousy, intoxication, emotional need, etc.), as was their employment and marital status at the time of the offence. Victim details included the relationship to the offender, gender, age, and the degree of physical and psychological injury sustained due to the abusive behaviour (minor: the victim required minimal medical/psychological intervention; moderate: victim may have required medical attention but was not admitted to hospital/ follow-up counselling but not on-going; substantial: short term hospital stay/long-
term counselling; very extensive: long term medical care/serious psychological disturbance; and for physical injury, caused death).

Details about the index offence were encoded from pre-referral sources and notes recorded by Cedar Cottage staff at the time of the assessment interviews. Reports of the most severe conduct were recorded. For example, if the victim described digital penetration in a police interview, but the offender denied this behaviour, digital penetration was recorded. If the offender made disclosures that exceeded the victim’s statement, such as stating that vaginal penetration occurred where a victim failed to disclose this type of abuse, vaginal penetration was recorded.

Sections One through Three were coded for all offenders, regardless of acceptance into the program. Sections Four and Five were treatment-specific, thus were coded only for offenders who were accepted into the program.

Section Four recorded information about face-ups provided to the nonoffending parent, child victim, siblings, and others during assessment and treatment, and whether these face-ups matched or extended on the victim’s statement of the sexually abusive conduct. The status of treatment was recorded (e.g., completed, started but incomplete, offender refused to participate), and the types of treatment received prior to contact with Cedar Cottage were noted (drug or alcohol interventions, gambling counselling, marital or relationship counselling, anger management). The degree to which the offender matched the victim’s statement and accepted responsibility for the offence was recorded.

In Section Five, the quality of the case file was rated, specifically whether there information about the identification of risk factors, the offenders’ progress through treatment, the impact of treatment on risk of reoffending, recommendations for follow-up, and sexual arousal assessment. Each variable was coded from 0 (not included) to 3 (the information was in the report, was clear and complete, statements were thoroughly explained and supported).

Data were collected by 11 student interns who were trained by staff from Cedar Cottage on the use of the coding instrument. All student coders signed confidentiality agreements and received appropriate supervision regarding the topic of the research.

**Interrater reliability**

Interrater reliability was calculated to establish the extent of consensus by coders in using the coding instrument. Three methods to assess interrater reliability were computed: percent agreement, Fleiss free-marginal kappas and intraclass correlation coefficients. Twenty-five case files were double-coded by different raters (11.6% of the total sample). Consensus between raters was measured by the number of agreements divided by the total number of observations (percent agreement). The raters agreed on 84.75% of the observations, yielding a high level of interrater reliability. Reliability estimates ranged from 71.4 - 91.6% agreement (mode= 90.8%; median= 85.7%).

Fleiss free-marginal kappas were calculated for 67 of the 112 coded variables. Values of kappa lower than 0.4 were considered unacceptable, values between 0.4 and 0.6 were considered to be poor, values between and including 0.6 and 0.8 were considered to be fair, and values above 0.8 were considered to be good reliabilities (Randolph, 2007). Table 54 in Appendix G shows the 25 Fleiss kappa statistics calculated for the double-coded files. Overall, the interrater reliabilities were good or fair for most cases; only two case files had unacceptable interrater reliabilities (i.e., Fleiss kappa below .60). Sixteen
files had kappas between 0.6 and 0.8 (13 were above 0.7), and the remaining seven cases were above 0.8, suggesting overall good interrater reliabilities among these variables.

Intraclass correlation coefficients (ICC) were calculated for the 45 ordinal variables and 6 continuous variables. Equal distancing between the ordinal variables was assumed. Values of ICC between 0.4 and 0.6 were considered as indicators of poor reliability, 0.60 to 0.79 as adequate reliability, and 0.80 as good reliability (Landis & Koch, 1977). Table 55 in Appendix G shows the 25 ICCs calculated for the double-coded files. Overall, the intrarater reliabilities were adequate to good for most cases; only one case had unacceptable intrarater reliability (i.e., ICC below 0.6). Six files had ICCs between 0.6 and 0.79, eight had reliabilities between 0.80-0.89 and nine cases had reliabilities above 0.9. These results indicated overall good intrarater reliability. The average ICC for all 25 case files was 0.84, and the mean weighted ICC was 0.97 (variance 2.10).

Criminal records
Recidivism data were obtained from the NSW Police and the NSW Bureau of Crime Statistics and Research Reoffending Database (ROD). Both agencies were provided with a list of offender names, dates of birth, dates of referral to Cedar Cottage and Central Names Index (CNI) numbers (where available). Offending data were requested through October 1st, 2007.

Recidivism and criminal history data for the study sample were obtained from the Computerised Operational Policing System (COPS) maintained by the NSW Police. This is the main database used to record information pertaining to criminal events and includes charge information recorded in New South Wales. Information within the COPS database is occasionally supplemented with information from the NSW Criminal Histories System (CHS) database. The CHS database is maintained by court staff and records convictions in NSW, appeals of convictions and those outcomes. Information is entered when individuals make a court appearance, at which time a search is conducted of criminal prior activity and offences. Information obtained from other jurisdictions is rarely available.

The COPS database has been in regular use since 1994, and includes some records from the time period 1988-1994. Two types of reports are included in COPS: (a) reports of criminal incidents and information reports which include general beliefs the police may hold about criminal conduct, and (b) intelligence reports provided by members of the public. These information reports are not necessarily offence specific. Offence information prior to 1988 is less comprehensive than information stored post-1994, and is accessed by searching microfiche records.

The NSW Police provided information including each offender’s identifying details (name, DOB, address, etc.), the type of offence or incident for which they came to the attention of the police (e.g., “common assault”, “cultivate prohibited plant”), the reported date and incident date, the location where the incident occurred, and victim details including name, gender, date of birth, and relationship to offender. Where known, the outcome of the report/charge was provided (e.g., charged, found guilty, incarceration), alongside any further information which better described the event.

The data obtained from BOCSAR provided similar identifying details to the NSW Police database, alongside the jurisdiction in which the matter was raised (local or district court), the offence category (Australian Standard Offence Category, ABS, 1997), the date on which the offence occurred, the outcome (e.g., guilty, dismissed), and the penalty awarded when offenders were convicted.
The process of cleaning the datasets, identifying gaps and seeking missing information was a time-consuming, but necessary task to protect the integrity of the data and minimise errors in recidivism estimates. Where the NSW Police database omitted required information about a, offender’s record (such as the date of the offence), a query was issued to them for further investigation. Queries about an offender’s criminal record were sent to the Director of Cedar Cottage when the missing information was qualitative (e.g., to clarify the relationship between the offender and the victim of an offence).

Information contained in these two databases was collated and crosschecked, and classed as either criminal history or recidivism based on whether the date of the offence occurred prior to or after the index offence. Where discrepancies arose between the NSW Police database and the dataset provided by BOCSAR, police data were given precedence due to the more extensive level of detail in these records. When coding the date of the offence or report, the incident date was used where possible. If this was not available, the report date was used, followed by the charge date. If none of these dates were available, a query was sent to the police for further information. Since ROD includes data from 1994 onwards, data prior to 1994 were gathered exclusively from police records. A strength of this study is the accuracy of the database, enhanced by cross-checking post-1994 records listed by ROD against data from the NSW Police.

Criminal records were classified according to the level of report provided (report made to police, charge, or conviction) and type of offence: sexual offences (non-contact sexual offences, indecent assault, and sexual assault), violent offences, and nonsexual nonviolent offences. Nonsexual nonviolent offences include driving offences, drug offences, theft, fraud, break and enter, justice offences such as breach of bail, and others. Apprehended Violence Orders (AVOs) were included as a separate category, as were breached AVOs.

The Department of Corrective Services (DCS) provided data regarding length of incarceration of offenders whom they were able to match using the same information as was provided to the Police and BOCSAR. Where information indicated that an offender was incarcerated following his contact with Cedar Cottage, the observation period for that individual was terminated. These data refined the analyses so that offenders who were not available in the community to offend were not included with the non-offenders. Where discrepancies existed, requests were made of DCS for further details to enable closer matching of offenders with DCS records (DCS identified five individuals who received treatment in the CORE and/or CUBIT programs while incarcerated so that the impact of this treatment on recidivism rates in this group could be assessed).

Two offenders who did not complete treatment (one declined entry, one who breached) committed further offences prior to their referral and during the assessment period. The offender who was not accepted committed a number of indecent assaults over a period of one year against a victim other than the index victim. These assaults were reported only two years after they had ceased, and did not lead to charges as the victim withdrew the statement. The offender who breached from treatment breached the AVO that his stepdaughter and wife had against him for a period starting four days before his date of referral and continued to do so for three months. These breaches resulted in seven charges, which were later dismissed. The period of time for these offenders to recidivate was coded as zero.

One offender who was not accepted into the program breached an AVO brought by his ex-wife five times whilst in custody. Each breach resulted in a conviction. The period of time for this offender to recidivate was coded as zero.
Summary

The research design applied in this study included all offenders referred to Cedar Cottage in the period 1989-2003. Eligible intrafamilial sex offenders who were referred to Cedar Cottage but declined treatment served as the control group in this evaluation, and were compared to offenders in the group accepted for treatment. Statistical tests established good interrater reliability of the information extracted from the Cedar Cottage clinical files. Official reports of reoffending were compiled from the NSW Police Computerised Operational Policing System and the NSW Criminal Histories System database. Records of subsequent convictions were derived from the NSW Police and cross-checked against records in the NSW Bureau of Crime Statistics and Research Reoffending Database. These parameters were selected to test the effectiveness of the Pre-Trial Diversion Program in reducing sexual reoffending. At a minimum, this robust design achieved Level Three on the Maryland Scale of Scientific Rigour.
CHAPTER 6
CHARACTERISTICS OF THE SAMPLE, INDEX OFFENCES AND VICTIMS

Time in treatment .................................................................................................................................... 62
Demographic characteristics of offenders ............................................................................................... 62
Aboriginals and Torres Strait Islanders ............................................................................................... 62
Offender relationship to victim ........................................................................................................... 62
Age of offenders at referral and first abuse ....................................................................................... 63
Marital status ...................................................................................................................................... 64
Employment history ............................................................................................................................ 65
History of substance abuse and mental illness................................................................................... 66
Experiences of childhood sexual, physical and emotional abuse ....................................................... 67
Offender history of criminal conduct .................................................................................................. 68
Retrospective STATIC-99 scores .......................................................................................................... 71
Victim characteristics ............................................................................................................................... 72
Index offence characteristics................................................................................................................ 74
Acceptance of responsibility following treatment ................................................................................... 81
Face-ups .............................................................................................................................................. 82
Comparison of offenders referred before and after 1993 ....................................................................... 83
Summary .................................................................................................................................................. 85
CHAPTER 6
CHARACTERISTICS OF THE SAMPLE, INDEX OFFENCES AND VICTIMS

The study sample consisted of 214 male offenders who were referred to Cedar Cottage from the date of the program inception until December 31, 2003. Offenders who were not deemed suitable for treatment (57%, n=121) comprise the control group and are referred to throughout this report as the Declined Group. Outcomes for the declined group are compared with those for offenders who entered the program for treatment (43%, n=93), referred to as the Accepted Group. Offenders who completed the treatment program in either two or three years (25%, n=53) are referred to as Completers, whereas offenders in the accepted group who terminated treatment prior to completion, either because they voluntarily withdrew from the program (4%, n=8), or because they breached the terms of the treatment agreement (15%, n=32), are referred to as Noncompleters. The proportion of offenders in each of these four groups is displayed in Figure 3.

Figure 3. NSW Pre-Trial Diversion Program Referrals 1989-2003

Throughout this report, the major comparison of interest is between the Declined and Accepted Groups. Differences between Completers and Noncompleters are included to provide more details about the influence of treatment completion. In addition, since the biological relationship between offenders and victims is central to the definition of intrafamilial sexual offending, results are reported for biological versus nonbiological fathers.

To establish whether pre-existing factors or the assessment period at Cedar Cottage served to distinguish the Declined from the Accepted groups in ways that might account for any differences observed in subsequent rates of reoffending, similarities and differences between offenders declined and accepted for treatment were investigated, i.e., their demographic profiles, victim characteristics, offence patterns and levels of acceptance of responsibility.

The results of these analyses are presented in five sections: First, we review time in treatment. Second, demographic characteristics of the offenders are presented: cultural background, relationship to victim, marital status, employment status, mental health history, past childhood abuse, age at date of referral, and past criminal conduct. Third, we review characteristics of their victims. These included
victim gender, victim age at first abuse, number of known victims, and age of youngest victim. Fourth, features of the index offence are analysed, including duration of offending, number of incidents of abuse, types of abusive acts, number of charges, intrusiveness of abusive conduct, coercive abusive tactics, and the nature of injuries sustained by victims. Finally, we examine offender acceptance of responsibility, a key element of the treatment program.

Unless otherwise stated, statistical significance in the following two chapters is tested using an alpha level of 0.05.

**Time in treatment**

Offenders accepted into the program spent an average of two years (23.4 months) in treatment. Treatment completers spent significantly longer in the program than those who breached or withdrew ($F (2, 90) = 72.73, \eta^2=0.62$). Treatment completers spent an average of 31.5 months in the program, twice as long as offenders who breached (15.8 months), and three times as long on average than offenders who voluntarily withdrew from the program (11.1 months). Differences in time spent in treatment by offenders who breached and withdraw from the program were not statistically significant. The relatively small group of 8 offenders who voluntarily withdrew from the program was combined with 32 offenders who breached to comprise the group of treatment noncompleters (19% of the total sample).

**Demographic characteristics of offenders**

Program applicants completed a self-report form requesting demographic information prior to the initial assessment interview. Offenders accepted into the program and offenders declined treatment were compared on all major demographic indicators. Bonferroni-adjusted independent samples t-tests were conducted to determine if the groups differed significantly on demographic variables. This number of comparisons required the alpha level to be set at 0.007 to avoid Type 1 errors. Results revealed that on most demographic indicators, there were no significant differences between offenders accepted and declined, as discussed below.

**Aboriginals and Torres Strait Islanders**

Fourteen (6.5%) offenders identified as Aboriginal or Torres Strait Islander at referral to treatment. Nine offenders who self-identified as Aboriginal or Torres Strait Islander were declined entry into the program; five were accepted for treatment (7.4% and 5.4% respectively). Two Aboriginal offenders successfully completed treatment (3.8% of the completers); the remaining three breached from the program (7.5% of noncompleters). The small number of Aboriginal offenders precluded analyses of differences between Aboriginal and nonaboriginal groups.

**Offender relationship to victim**

Nonbiological fathers comprised the majority of the sample (55.1%, $n= 118$), while biological fathers comprised 44.9% ($n=96$) of the offenders. Both groups were equally likely to be accepted into the program. Once accepted, biological and nonbiological fathers were equally likely to complete treatment successfully. The distribution of biological and nonbiological fathers was approximately even in all groups, as shown in Table 7. There were no statistically significant differences between biological and nonbiological fathers with respect to acceptance into or completion of the treatment program.
Table 7. Offender relationship to victim, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined</td>
<td>54.2</td>
<td>58.5</td>
<td>56.5</td>
</tr>
<tr>
<td>Accepted</td>
<td>45.8</td>
<td>41.5</td>
<td>43.5</td>
</tr>
<tr>
<td>Completed</td>
<td>24.0</td>
<td>25.4</td>
<td>24.8</td>
</tr>
<tr>
<td>Breached</td>
<td>16.7</td>
<td>13.6</td>
<td>15.0</td>
</tr>
<tr>
<td>Withdrew</td>
<td>5.2</td>
<td>2.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Total n</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

Age of offenders at referral and first abuse

The mean age of applicants at the time they were referred to the program was 39.5 years. The mean age of offenders who were declined treatment was 39.7 years, whereas offenders accepted for treatment were 39.4 years of age. On average, offenders who completed treatment were 4 years older than noncompleters (mean ages of 41.3 vs. 36.9 years), a statistically significant difference \[ t (91) = -3.08, d = 0.65 \].

Biological fathers were significantly older than nonbiological fathers at the time of referral \[ t (212)= 3.24, d = 0.45 \] (mean ages= 41.4 vs. 38.0 years, respectively). Figure 4 displays the age differences between offender groups at the time of referral.

A similar pattern of results emerged with regard to the age of offenders at the first reported incident of abuse. The mean age of offenders at the time they committed their first abusive act was 36.3 years. There was no significant difference in the mean age at first incident of abuse of offenders accepted versus declined treatment.

Figure 4. Offender age (mean years) at time of referral, by group

An average of three years passed between the time that offenders committed their first abusive act and the time they were referred to the program. Program completers were significantly older at the time of first abuse than were program noncompleters (\(M= 38.14 \) vs. 33.79 years, respectively) \[ t (91) = 3.24, d = 0.68 \], and biological fathers were significantly older at the time of first abuse than were nonbiological fathers (\(M= 37.76 \) vs. 35.13 years, respectively) \[ t (211) = 2.58, d = 0.36 \]. Table 8 displays the age ranges by offender group.
Table 8. Age range of offenders at first incident of reported abuse, by group (percent)

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>5.7</td>
<td>3.2</td>
<td>3.8</td>
<td>2.5</td>
<td>2.1</td>
<td>5.9</td>
<td>4.7</td>
</tr>
<tr>
<td>25-29</td>
<td>9.8</td>
<td>11.8</td>
<td>5.7</td>
<td>20.0</td>
<td>5.2</td>
<td>15.3</td>
<td>10.7</td>
</tr>
<tr>
<td>30-34</td>
<td>30.3</td>
<td>25.8</td>
<td>20.8</td>
<td>32.5</td>
<td>29.2</td>
<td>28.0</td>
<td>28.4</td>
</tr>
<tr>
<td>35-39</td>
<td>23.8</td>
<td>30.1</td>
<td>26.4</td>
<td>35.0</td>
<td>30.2</td>
<td>23.7</td>
<td>26.5</td>
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<td>40-44</td>
<td>16.4</td>
<td>18.3</td>
<td>26.4</td>
<td>7.5</td>
<td>19.8</td>
<td>15.3</td>
<td>17.2</td>
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<td>45-49</td>
<td>4.9</td>
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<td>4.2</td>
<td>8.5</td>
<td>6.5</td>
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<tr>
<td>50-54</td>
<td>4.9</td>
<td>1.1</td>
<td>1.9</td>
<td>-</td>
<td>5.2</td>
<td>1.7</td>
<td>3.3</td>
</tr>
<tr>
<td>55-59</td>
<td>2.5</td>
<td>1.1</td>
<td>1.9</td>
<td>-</td>
<td>3.1</td>
<td>0.8</td>
<td>1.9</td>
</tr>
<tr>
<td>60-64</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>65-69</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>Missing</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.8</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Sum</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

Marital status

Most offenders (85.1%) were in a legal or common law marriage at the time of the index offence. Legal marriage was the most common status (63.6%); a common law marriage less frequent (21.5%). Offender marital status was compared to Australian Bureau of Statistics marital statistics in 2006 for males aged 25-64 years, living in New South Wales. Since men in common law marriages are counted as “single/never married” no comparison of that group was feasible. Overall, offender marital status was comparable to that in the general NSW population. Table 9 displays offender marital status by offender group.

Table 9. Offender marital status, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Total</th>
<th>ABS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single/never married</td>
<td>3.3</td>
<td>1.1</td>
<td>-</td>
<td>2.5</td>
<td>2.3</td>
<td>27.7</td>
</tr>
<tr>
<td>Common law marriage</td>
<td>24.8</td>
<td>17.2</td>
<td>20.8</td>
<td>12.5</td>
<td>21.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Legal marriage</td>
<td>59.5</td>
<td>68.8</td>
<td>69.8</td>
<td>67.5</td>
<td>63.6</td>
<td>59.4</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>9.9</td>
<td>12.9</td>
<td>9.5</td>
<td>17.5</td>
<td>11.2</td>
<td>12.2</td>
</tr>
<tr>
<td>Widowed</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.5</td>
<td>0.7</td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>214</td>
<td>N/A</td>
</tr>
</tbody>
</table>

There was a statistically significant relationship between offender relationship to victim and marital status. Biological fathers were more likely to be in a legal marriage than were nonbiological fathers (67.7% vs. 61.2%), while nonbiological fathers were more likely to be in a common law marriage than were biological fathers (30.2% vs. 11.5%) ($\chi^2 = 14.90$, df = 4, N= 212), as shown in Table 10.
**Table 10. Offender marital status, by relationship to victim (percent)**

<table>
<thead>
<tr>
<th></th>
<th>Biological</th>
<th>Nonbiological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single/never married</td>
<td>3.1</td>
<td>1.7</td>
</tr>
<tr>
<td>Common law marriage</td>
<td>11.5</td>
<td>30.2</td>
</tr>
<tr>
<td>Legal marriage</td>
<td>67.7</td>
<td>61.2</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>16.9</td>
<td>6.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>1.0</td>
<td>-</td>
</tr>
</tbody>
</table>

**Employment history**

The majority of offenders had a history of past steady employment (60.3%), while 10.3% were identified as having difficulty maintaining steady employment. There was a significant relationship between entry to the program and employment status ($\chi^2 = 9.91$, df= 3, N= 210; see Table 11). Those declined entry to the treatment program were less likely to maintain steady employment than those accepted for treatment (52.1% vs. 71.0%). Offenders who did not complete treatment were equally likely to maintain steady employment as those who completed the program. More biological than nonbiological fathers maintained steady employment, although this difference was not significant.

**Table 11. Offender employment history, by group (percent)**

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleters</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steady employment</td>
<td>52.1</td>
<td>71.0</td>
<td>79.2</td>
<td>60.0</td>
<td>65.5</td>
<td>55.9</td>
<td>60.3</td>
</tr>
<tr>
<td>Sporadic employment</td>
<td>16.5</td>
<td>11.8</td>
<td>11.3</td>
<td>12.5</td>
<td>13.5</td>
<td>15.3</td>
<td>14.5</td>
</tr>
<tr>
<td>Difficulty maintaining employment</td>
<td>11.6</td>
<td>8.6</td>
<td>3.8</td>
<td>15.0</td>
<td>8.3</td>
<td>11.9</td>
<td>10.3</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>18.2</td>
<td>6.5</td>
<td>3.8</td>
<td>10.0</td>
<td>10.4</td>
<td>15.3</td>
<td>13.1</td>
</tr>
<tr>
<td>Missing</td>
<td>1.7</td>
<td>2.2</td>
<td>1.9</td>
<td>2.5</td>
<td>2.1</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

At the time of the index offence, the majority of offenders were employed (including self-employment). Approximately one quarter of the group declined treatment was unemployed. Similar rates of unemployment were observed in nonbiological parents. There was a significant relationship between offenders program entry status and employment status at the time of the offence ($\chi^2 = 13.8$, df= 6, N= 212). Offenders accepted for treatment were more likely to be employed than those declined entry (75.3% vs. 55.4%). Differences in employment rates between completers and noncompleters and biological versus nonbiological fathers were not significant. Table 12 displays the employment status of offenders by group at the time of the index offence.
Table 12. Employment status at the time of index offence, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed (incl. self-employed)</td>
<td>55.4</td>
<td>75.3</td>
<td>77.4</td>
<td>72.5</td>
<td>67.7</td>
<td>61.0</td>
<td>64.0</td>
</tr>
<tr>
<td>Unemployed</td>
<td>25.6</td>
<td>20.4</td>
<td>18.9</td>
<td>22.5</td>
<td>19.8</td>
<td>26.3</td>
<td>23.4</td>
</tr>
<tr>
<td>Student</td>
<td>2.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
<td>1.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Disability pensioner</td>
<td>5.0</td>
<td>3.2</td>
<td>3.8</td>
<td>2.5</td>
<td>5.2</td>
<td>3.4</td>
<td>4.2</td>
</tr>
<tr>
<td>Retired</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>3.3</td>
<td>1.1</td>
<td>-</td>
<td>2.5</td>
<td>4.2</td>
<td>0.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>5.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Missing</td>
<td>1.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
<td>0.8</td>
<td>0.9</td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

History of substance abuse and mental illness

A history of substance abuse or mental illness is not a bar to participation in the Cedar Cottage treatment program. When individuals accepted for treatment have substance abuse or other mental health problems, the staff at Cedar Cottage collaborate with third parties and other agencies to address those issues. In general, a minority of offenders present with these problems, although a history of substance abuse is more commonly encountered than is mental illness.

A history of substance use was reported by one in four or one in five offenders during the assessment period. As many as 22% of offenders reported a history of alcohol or other drug abuse unrelated to the offence, and a further 19.6% of offenders identified alcohol or other drug abuse directly linked to the commission of the index offence. Offenders accepted for treatment were significantly more likely to have a substance abuse history related or unrelated to the commission of their offence than those declined entry (47.3% and 37.2% respectively) \( (\chi^2 = 23.0, \text{df}= 3, N= 212) \). Treatment noncompleters were twice as likely to report a substance abuse history unrelated to the commission of their offences than were treatment completers (36% vs. 17.0%). This trend was reversed for use of alcohol and other drugs at the time of offending, with 30.2% of completers identifying substance use at the time of abuse versus 12.5% of noncompleters \( (\chi^2 = 31.7, \text{df}= 6, N= 212) \). More nonbiological fathers (22%) reported that substance use was linked to the commission of the abuse than did biological fathers (16.7%). However, more biological than nonbiological fathers reported a history of alcohol and other drug use (24% vs. 20.3% respectively). These differences between biological and nonbiological fathers were not statistically significant.

Affective disorders, past and current, were more common in offenders than thought disorders. However, there was no difference between offenders with a history of or present affective disorder and their likelihood to have substance use linked to their offending behaviour. Those with a history of affective disorder were more likely to have a substance abuse history that was unrelated to their offending than were those with a current affective disorder or no history of affective disorder, as shown in Table 13. Only one offender was referred to Cedar Cottage with a history of thought disorder. In that case, drug or alcohol use was linked to the commission of the offences. Five offenders were referred with a current thought disorder (medicated or not). Three of these offenders had a history of drug or alcohol abuse, one had no drug or alcohol history, and there was no information available about substance abuse by the remaining offender.
Table 13. Offender history of affective disorder, by substance abuse history (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>No history of affective disorder</th>
<th>History of affective disorder</th>
<th>Presence of affective disorder</th>
<th>Insufficient information</th>
</tr>
</thead>
<tbody>
<tr>
<td>No AOD history</td>
<td>44.0 (11)</td>
<td>25.0 (1)</td>
<td>34.8 (8)</td>
<td>15.6 (24)</td>
</tr>
<tr>
<td>AOD use unrelated to offences</td>
<td>16.0 (4)</td>
<td>50.0 (2)</td>
<td>34.8 (8)</td>
<td>21.4 (33)</td>
</tr>
<tr>
<td>AOD related to offences</td>
<td>24.0 (6)</td>
<td>25.0 (1)</td>
<td>26.1 (6)</td>
<td>18.2 (28)</td>
</tr>
<tr>
<td>Total</td>
<td>100 (25)</td>
<td>100 (4)</td>
<td>100 (23)</td>
<td>100 (154)</td>
</tr>
</tbody>
</table>

AOD = alcohol or drug

Mental illness was less prevalent than substance abuse. Relatively few offenders (2.3%, n=5) were diagnosed with a major mental illness at the time of referral (e.g., psychotic disorder, schizophrenia, or major depression), whether medicated or not. Professionally diagnosed affective disorders at the time of referral were reported in 10.7% (n=23) of offenders (e.g., depression or mania, medicated or not). By contrast, a small proportion (1.9%, n=4) had a history of affective disorder. Persons accepted for treatment were significantly more likely to have a historical or current affective disorder than those declined entry (14.0%, n=13 vs. 11.6%, n=14 respectively) \((\chi^2 = 10.8, df= 3, N= 207)\). The prevalence of historical or current affective disorder among offenders who completed the program (15.1%, n=8) exceeded that among noncompleters (12.5%, n=5). Biological and nonbiological fathers reported similar rates of historical (1%, n=1 vs. 2.5%, n= 3) or current affective disorders (11.5%, n=11 and 10.2%, n=12 respectively). Differences between completers and noncompleters and between biological and nonbiological fathers were not statistically significant.

Experiences of childhood sexual, physical and emotional abuse

Starting in June, 1995, program participants were required to compile a personal biography in which they reviewed their experiences of harm. Treatment files prior to 1995 included fewer records from which to glean this information.

Almost half of the offenders (46%) were victims of either childhood sexual, physical or emotional abuse (before the age of 16 years), as is shown in Figure 5. Offenders who reported a history of victimisation were significantly more likely to be accepted into the program than declined \((\chi^2 = 23.4, df= 1, N= 214)\). Abuse history was not significantly related to treatment completion or the offender’s relationship to the victim (biological vs. nonbiological fathers).

Overall, a substantial proportion of offenders (37.9%) self-reported that they were victims of childhood sexual abuse. A further 3.7% of offenders had witnessed the sexual abuse of another as children. In all, 22.9% of the offenders reported childhood physical or emotional abuse; 4.7% had witnessed physical or emotional abuse of others.

The majority of the offenders who experienced childhood sexual abuse were victims of a male perpetrator (69.7%), and two-fifths (42.7%) were abused by a relative (e.g. parent, sibling, uncle, or grandparent). Information about the identity of the abuser was not available for three offenders. Abuse by a female perpetrator was less common (11.2%; gender of the perpetrator was not recorded in 11.2% of the records); abuse by both male and female perpetrators (7.7%) was more rare. Of the seven offenders who witnessed sexual abuse of others, six reported that their father was the perpetrator, and
in five cases the victim was the offender’s sister. In one case, the offender observed his cousins sexually abusing other children.

Figure 5. Self-reported history of childhood abuse in offenders (percent)

Offender history of criminal conduct
To determine the extent to which offenders referred to Cedar Cottage were one-off sexual offenders or had more criminal proclivities, offending behaviours prior to the index offence were investigated at the most inclusive level available in official police records (report) and at the most stringent level (conviction). A comparison of these figures illustrates the disparate rates of offending conduct that emerge when different definitions of offending behaviour are applied. When police reports are taken into account, more than half (54.7%) of the offenders in the study sample revealed some history of criminal offending, but the proportion dropped to 45% when only prior convictions are examined. These proportions were both somewhat higher among offenders declined treatment (59.5% had reports, 51.2% were convicted) than among offenders who entered the program (48.4% had reports, 37.6% were convicted). More program noncompleters than completers had a history of prior criminal offending (report = 60%, convictions = 55% vs. report = 39.6%, convictions = 24.5%). The difference between program completers and noncompleters criminal history as measured by convictions was statistically significant (55% vs. 24.5%; $\chi^2 = 9.02$, df= 1, N= 93). Nonsexual, nonviolent offences comprised the most common past criminal offences.

Figure 6 shows that offenders who were accepted and declined treatment had similar proportions of official reports of prior criminal conduct, overall and with respect to sexual, violent and other nonsexual non-violent offences. Notwithstanding the fact that one of the eligibility criteria for referral of an offender to Cedar Cottage by the Office of the Director of Public Prosecutions is the absence of any prior conviction for a sexual offence (see Chapter Two), the police data revealed that 7% of the offenders, or 15 referrals had been convicted of a sexual offence as an adult. Of this group, seven were accepted for treatment and eight were declined, as is shown in Table 16.
When prior convictions are examined, as is shown in Figure 7, the proportions of prior criminal offences in offenders in the accepted and declined groups were also similar.

These results demonstrated that many offenders referred to Cedar Cottage were not one-off offenders, and that their offending behaviours were not confined to sexually deviant acts with minors.

Two-thirds of the 117 offenders who had a history of prior offending committed these offences during adulthood (65.8%, n=77); the remaining one-third (33.9%, n=39) commenced offending during adolescence and continued into adulthood. One offender (0.5%) had a juvenile record and no record of subsequent adult offences. Table 14 provides a more detailed picture of juvenile and adult offence rates by group. No significant differences emerged between groups.
Table 14. Age of offender at time of prior offending by group (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No past offending</td>
<td>39.7 (48)</td>
<td>52.7 (49)</td>
<td>62.3 (33)</td>
<td>40.0 (16)</td>
<td>45.3 (97)</td>
</tr>
<tr>
<td>Juvenile offending only</td>
<td>0.8 (1)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.5 (1)</td>
</tr>
<tr>
<td>Adult offending only</td>
<td>37.2 (45)</td>
<td>34.4 (32)</td>
<td>30.2 (16)</td>
<td>40.0 (16)</td>
<td>36.0 (77)</td>
</tr>
<tr>
<td>Juvenile and adult</td>
<td>22.3 (27)</td>
<td>12.9 (12)</td>
<td>7.5 (4)</td>
<td>20.0 (8)</td>
<td>18.2 (39)</td>
</tr>
<tr>
<td>offending</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0 (121)</td>
<td>100.0 (93)</td>
<td>100.0 (53)</td>
<td>100.0 (40)</td>
<td>100.0 (214)</td>
</tr>
</tbody>
</table>

Offenders accepted for treatment were less likely to have a juvenile offending record than those declined treatment (12.9% vs. 23.0%). Program completers were less likely to have a juvenile record (7.5%), than were noncompleters (20.0%). Neither difference was statistically significant.

Chi-Square analyses were conducted to investigate whether there was a relationship between offenders who had a prior history of violent offending and entry to the program. The results revealed that declined offenders had significantly more prior violent reports and convictions than did accepted offenders (reports: $\chi^2=12.67$, df=1, N=214; convictions: $\chi^2=16.84$, df=1, N=214). A series of comparisons of offenders accepted versus declined were conducted on prior offences, by type of offence, using Bonferroni-adjusted independent nonparametric Mann-Whitney tests (alpha= 0.006). These analyses revealed that offenders who were declined treatment were significantly more likely to have violent offence histories than offenders accepted into treatment [Mean rank 116.65 vs. 95.60; $z = -3.56$, N=214]. No other significant differences emerged between the groups (see Table 15) with respect to reports of prior offences. A comparison of prior criminal offences in the records of treatment completers versus noncompleters revealed no significant differences on any type of offending.

Table 15. Prior offending reports and conviction, by offence type and group (percent)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All offences</td>
<td>59.5</td>
<td>51.2</td>
<td>48.4</td>
<td>37.6</td>
<td>39.6</td>
<td>24.5</td>
<td>60.0</td>
<td>55.0</td>
<td>54.7</td>
<td>45.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-contact sexual</td>
<td>1.7</td>
<td>1.7</td>
<td>1.1</td>
<td>1.1</td>
<td>-</td>
<td>-</td>
<td>2.5</td>
<td>2.5</td>
<td>1.4</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>offence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indecent assault</td>
<td>2.5</td>
<td>0.8</td>
<td>7.5</td>
<td>4.3</td>
<td>5.7</td>
<td>1.9</td>
<td>10.0</td>
<td>7.5</td>
<td>4.7</td>
<td>2.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual assault</td>
<td>6.6</td>
<td>1.7</td>
<td>5.4</td>
<td>2.2</td>
<td>1.9</td>
<td>1.9</td>
<td>10.0</td>
<td>2.5</td>
<td>6.1</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent offence</td>
<td>28.1</td>
<td>23.1b</td>
<td>8.6b</td>
<td>3.2b</td>
<td>9.4</td>
<td>1.9</td>
<td>7.5</td>
<td>5.0</td>
<td>19.6</td>
<td>14.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breach AVO</td>
<td>5.0</td>
<td>3.3</td>
<td>1.1</td>
<td>-</td>
<td>1.9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3.3</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-sexual, non-violent</td>
<td>49.6</td>
<td>45.5</td>
<td>35.5</td>
<td>33.3</td>
<td>24.5</td>
<td>20.8</td>
<td>50.0</td>
<td>50.0</td>
<td>43.5</td>
<td>40.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>offence</td>
<td>N/A</td>
<td>4.1</td>
<td>N/A</td>
<td>2.2</td>
<td>N/A</td>
<td>1.9</td>
<td>N/A</td>
<td>2.5</td>
<td>N/A</td>
<td>3.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Numbers include records of juvenile and adult offences; Rep = official report; Conv = conviction
* Pairs with same superscripts are significantly different (p < 0.01)
The disparity between police reports and prior convictions for sexual offending behaviours is of particular interest. As shown in Table 16, approximately 1 in every 10 offenders in the study sample (11.2% of all referrals) had some history of prior sexual offending, although this ratio drops to less than 1 in 20 (4.7%) when convictions are taken into account. Of these, more offenders had a history of adult as opposed to juvenile offending (7% vs. 4.2%). There were no significant differences in the proportion of offenders with prior sexual offending histories who were accepted or declined for treatment in the Cedar Cottage program. However, this history differentiated program completers from noncompleters: one in every five noncompleters had a record of some prior sexual offending (20%, n= 4), whereas the ratio of completers with this history was one in 20 (5.7%, n= 3). These differences were not statistically significant, probably because of the small numbers (a total of 11 offenders) and low statistical power.

Table 16. Prior sexual offences by group (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult offenders</td>
<td>6.6 (8)</td>
<td>7.5 (7)</td>
<td>3.8 (2)</td>
<td>12.5 (5)</td>
<td>7.3 (7)</td>
<td>6.8 (8)</td>
<td>7.0 (15)</td>
</tr>
<tr>
<td>Juvenile offenders</td>
<td>4.1 (5)</td>
<td>4.3 (4)</td>
<td>1.9 (1)</td>
<td>7.5 (3)</td>
<td>4.2 (4)</td>
<td>4.2 (5)</td>
<td>4.2 (9)</td>
</tr>
<tr>
<td>Total</td>
<td>10.7 (13)</td>
<td>11.8 (11)</td>
<td>5.7 (3)</td>
<td>20.0 (8)</td>
<td>11.5 (9)</td>
<td>11.0 (13)</td>
<td>11.2 (24)</td>
</tr>
<tr>
<td>Convictions</td>
<td>4.1 (5)</td>
<td>5.4 (5)</td>
<td>1.9 (1)</td>
<td>10.0 (4)</td>
<td>4.2 (4)</td>
<td>5.1 (6)</td>
<td>4.7 (10)</td>
</tr>
</tbody>
</table>

Retrospective STATIC-99 scores

Information extracted from offender case files and police reports enabled retrospective computation of scores on the STATIC-99. The Static-99 is an actuarial risk assessment tool used to predict violent and sexual recidivism. It assesses ten static factors related to the offender: (1) age; (2) history of living with an intimate partner; (3) prior violent, nonsexual convictions; (4) prior nonsexual violence; (5) prior sex offences; (6) prior sentencing dates; (7) non-contact sex offences; (8) unrelated victims; (9) stranger victims; and (10) male victims.

On this scale, final scores of 0-1 indicate low risk, 2-3 indicate moderate-low risk, 4-5 reflect a moderate-high risk, while scores of six and above suggest a high risk of reoffending. The vast majority of offenders scored zero or one on this measure; few attained scores above four (see Figure 8). The results indicated that offenders referred to Cedar Cottage had a relatively low risk of recidivism as identified by this measure, and that the levels of risk observed in the declined and accepted groups were undifferentiated.
Victim characteristics

In fulfilment of the Cedar Cottage program goals to protect children and prevent further child sexual abuse in families where this has occurred, inquiries are made about the number, gender and age of index offence victims, and the scope of abuse perpetrated.

In this study, the contents of statements about the index offence reported during the assessment period following referral to Cedar Cottage by victims and offenders were objectively coded. This approach ensured that these data were gathered from multiple sources at an equivalent stage in the process, decreasing reliance on information recorded in the charge documents and maximising the opportunity for meaningful comparisons. Information about the index offence was missing for one offender, a nonbiological father who was declined entry to the program.

The majority of offenders referred to Cedar Cottage had one index victim (82.2%). The balance of the offenders in the study sample had between 2 and 5 index victims (13.1% had 2 index victims, 4.2% had 3 index victims; 1 offender had five index victims). No significant differences regarding the number of index abuse victims emerged between offenders accepted versus declined treatment, or between treatment completers and noncompleters. Biological fathers were not more likely than nonbiological fathers to have more than one victim. Figure 9 displays the percentage of offenders in each group who were referred with more than one index victim.
Most index victims were female children, with 91.1% of offenders targeting female children exclusively. Similar proportions of offenders abused male victims only (4.7%) or both male and female victims (4.2%). This pattern was replicated in all offender groups, as is shown in Table 17. There were no significant differences between offender groups with respect to the likelihood of abusing only female index victims.

Table 17. Gender of index victims, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female victims only</td>
<td>92.6</td>
<td>89.2</td>
<td>92.5</td>
<td>85.0</td>
<td>91.1</td>
</tr>
<tr>
<td>Male victims only</td>
<td>5.0</td>
<td>4.3</td>
<td>1.9</td>
<td>7.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Male and female victims</td>
<td>2.5</td>
<td>6.5</td>
<td>5.7</td>
<td>7.5</td>
<td>4.2</td>
</tr>
<tr>
<td>n</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>214</td>
</tr>
</tbody>
</table>

Biological fathers were somewhat more likely than nonbiological fathers to abuse only female children (93.8% versus 89.0%), but this difference was not statistically significant. Among nonbiological fathers, a higher proportion of offenders abused male victims only (5.9%) or both male and female victims (5.1%) than among biological fathers (3.1% of each). Table 18 displays the relationship between the gender of the victims of intrafamilial sexual abuse and biological versus nonbiological abusive parents. Due to the small number of male victims included in the study, no statistical tests were feasible on differences in the proportions of offenders who abused both male and female victims, or only male victims.

Table 18. Gender of child victims, by offender relationship to victim (percent)

<table>
<thead>
<tr>
<th></th>
<th>Biological</th>
<th>Nonbiological</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female victims only</td>
<td>93.8</td>
<td>89.0</td>
<td>91.1</td>
</tr>
<tr>
<td>Male victims only</td>
<td>3.1</td>
<td>5.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Male and female victims</td>
<td>3.1</td>
<td>5.1</td>
<td>4.2</td>
</tr>
</tbody>
</table>
The majority of the offenders committed abuses against victims under the age of ten years (58.9%), as is shown in Table 19. This pattern was replicated in all offender groups. Although proportionally more offenders who were declined than accepted for treatment offended against the youngest group of victims, under five years of age (16.6% vs. 11.8%), independent t-tests conducted on the age of victims revealed no significant differences between these groups. None of the offenders who successfully completed the program abused a victim older than 14 years of age.

Table 19. Age of youngest index victims, by group (percent)

<table>
<thead>
<tr>
<th>Age of youngest victim</th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4 years</td>
<td>16.5</td>
<td>11.8</td>
<td>7.5</td>
<td>17.5</td>
<td>14.5</td>
</tr>
<tr>
<td>5 – 9 years</td>
<td>39.7</td>
<td>50.5</td>
<td>40.0</td>
<td>40.0</td>
<td>44.3</td>
</tr>
<tr>
<td>10 – 14 years</td>
<td>34.7</td>
<td>33.3</td>
<td>32.5</td>
<td>32.5</td>
<td>34.1</td>
</tr>
<tr>
<td>15 years and older</td>
<td>2.5</td>
<td>2.2</td>
<td>5.0</td>
<td>5.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Missing</td>
<td>6.6</td>
<td>2.2</td>
<td>5.0</td>
<td>5.0</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Mean age of victim at first offence (years) | 8.6 | 8.3 | 8.3 | 8.3 | 8.5

Table 20. Age of youngest victims, by offender relationship to victim (percent)

<table>
<thead>
<tr>
<th>Age of youngest victim</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4 years</td>
<td>23.4</td>
<td>7.5</td>
<td>14.5</td>
</tr>
<tr>
<td>5 – 9 years</td>
<td>42.7</td>
<td>45.8</td>
<td>44.4</td>
</tr>
<tr>
<td>10 – 14 years</td>
<td>29.2</td>
<td>38.1</td>
<td>34.1</td>
</tr>
<tr>
<td>15 and older</td>
<td>3.1</td>
<td>1.7</td>
<td>2.3</td>
</tr>
<tr>
<td>Missing</td>
<td>2.1</td>
<td>6.8</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Mean age of victim at first offence (years) | 8.2 | 9.2 | 8.7

The same trend emerged when comparing the age range of the youngest victims of biological versus nonbiological fathers: the majority in both groups offended against victims under the age of ten years. Most of their youngest victims ranged between 5 and 9 years of age, as is shown in Table 20. However, three times as many biological than nonbiological fathers abused victims under the age of five years (23.4% vs. 7.5%; \( \chi^2=12.86, df=4, N=214 \)); whereas the proportion of nonbiological fathers who abused children aged 10-16 years exceeded that of biological fathers (38.1% vs. 29.2%). Independent samples t-tests demonstrated that on average, biological fathers abused significantly younger victims than did nonbiological fathers (Mean age youngest victim = 7.8 years vs. 9.1 years) \[ t (202) = -2.703, d=0.38 \].

**Index offence characteristics**

Table 21 provides an overview of index offence characteristics by offender group. The mean number of victims, charges, incidents of abuse, reported duration of the abusive behaviour and age of youngest victim were similar in the offender groups.
Table 21. Index offence characteristics (means)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Non-completed</th>
<th>Biological</th>
<th>Non-biological</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of victims</td>
<td>1.2 (1)</td>
<td>1.1 (1)</td>
<td>1.2(a)</td>
<td>1.3(b)</td>
<td>1.3 (1)</td>
<td>1.2 (1)</td>
<td>1.2 (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of charges</td>
<td>5.5</td>
<td>5.8</td>
<td>5.9</td>
<td>5.7</td>
<td>5.0</td>
<td>6.2</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of abusive incidents</td>
<td>147.4</td>
<td>106.2</td>
<td>125.4</td>
<td>78.83</td>
<td>122.7</td>
<td>133.6</td>
<td>128.7</td>
</tr>
<tr>
<td>Duration of offending (years)</td>
<td>3.3(b)</td>
<td>3.1(b)</td>
<td>3.1</td>
<td>3.1</td>
<td>3.6</td>
<td>2.9</td>
<td>3.2</td>
</tr>
<tr>
<td>Age of youngest victim (years)</td>
<td>8.6</td>
<td>8.3</td>
<td>8.4(c)</td>
<td>8.3(c)</td>
<td>7.8(d)</td>
<td>9.1(d)</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Note: Pairs with the same superscripts are significantly different (\(p < 0.01\)).

Bonferroni-adjusted independent samples t-tests were conducted to determine if the groups differed significantly on index offence characteristics. This number of comparisons required the alpha level to be set at 0.01 to avoid Type 1 errors. Statistically significant differences are noted in Table 21.

On average, the index offences of offenders accepted into the program entailed fewer incidents (88.3 vs. 104) and a shorter period of offending (3.1 vs. 3.3 years) than those of declined offenders. Completers had fewer victims (1.2) than noncompleters (1.3) and their victims were older (8.4 vs. 8.3 years). Victims of biological fathers were younger than those of nonbiological fathers (7.8 vs. 9.1 years).

Table 22. Number of charges against offenders at referral, by group

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10.7</td>
<td>8.6</td>
<td>7.5</td>
<td>10.0</td>
<td>12.5</td>
<td>7.6</td>
<td>9.8</td>
</tr>
<tr>
<td>2 – 5</td>
<td>57.9</td>
<td>52.7</td>
<td>47.2</td>
<td>60.0</td>
<td>58.3</td>
<td>53.4</td>
<td>55.6</td>
</tr>
<tr>
<td>6 – 10</td>
<td>17.4</td>
<td>26.9</td>
<td>34.0</td>
<td>17.5</td>
<td>17.7</td>
<td>24.6</td>
<td>21.5</td>
</tr>
<tr>
<td>11 – 15</td>
<td>6.6</td>
<td>5.4</td>
<td>5.7</td>
<td>5.0</td>
<td>7.3</td>
<td>5.1</td>
<td>6.1</td>
</tr>
<tr>
<td>16 – 20</td>
<td>4.1</td>
<td>3.2</td>
<td>3.8</td>
<td>2.5</td>
<td>4.2</td>
<td>3.4</td>
<td>3.7</td>
</tr>
<tr>
<td>21 and above</td>
<td>2.5</td>
<td>3.2</td>
<td>1.9</td>
<td>5.0</td>
<td>-</td>
<td>5.1</td>
<td>2.8</td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

Relatively few offenders, approximately 10%, were referred with only one charge, as shown in Table 22. Most commonly, offenders were facing between two and five charges at the time of referral (55.6%). The maximum number of charges faced by one offender was 43.

The number of incidents of abuse per index offence was calculated by auditing victim and offender statements (see Table 23). Where these details were not readily available, information in these statements about the frequency and duration of offending was used to estimate the number of times the abuse occurred. The majority of offenders and victims disclosed between two and ten incidents of abuse, although the range was broad, from a single incident to in excess of 2500 incidents.
The most common type of sexual conduct perpetrated by offenders was sexual touching or fondling: nine out of ten offenders committed this abusive act. Close to one half of the offenders admitted engaging in sexual exposure and exhibition, inviting the children to touch them sexually and performing oral sex on the victim (46.7%, 47.2% and 45.8%, respectively). Anal intercourse was the least common form of sexual abuse (7.9% of all offenders), and was more likely to be committed by offenders declined than accepted for treatment.

During the assessment period, the proportion of offenders accepted into treatment who disclosed all types of abusive acts against the index victim, with the exception of vaginal intercourse, exceeded that disclosed by their counterparts who were declined treatment. Table 24 demonstrates the types of abusive acts disclosed by offenders in each group.
The retrospective nature of the data gathered in the current study precluded measurement of social pressure or influence in relation to early versus later face-ups. These outcomes may be attributable in part to social and family pressures exerted on offenders entering treatment, who soon have to face the nonoffending parent and disclose their abusive conduct. Typically, it takes some time before offenders fully disclose the scope of their abusive behaviour to the nonoffending parent, particularly when this includes intercourse with the child. Offenders accepted into the program are more motivated to admit their misconduct than offenders who are denied treatment, but during the assessment period before treatment commences, they may find it easier to admit digital penetration than vaginal intercourse. By contrast, offenders who are declined treatment and who will proceed to a criminal trial (at which all sexual contact may be denied) are generally less motivated to admit to the full scope of their offending behaviour, as is reflected in the overall pattern of results, showing less extensive admissions than those by accepted offenders. With respect to the most severe forms of sexual abuse, anal and vaginal intercourse, perhaps because declined offenders are not subject to the pressures inherent in admitting their conduct to the nonoffending parent, their disclosures on these items exceed those of offenders accepted into treatment.

A common misperception of intrafamilial offenders is that their offences are one-off events, i.e., the abuse was committed on one occasion only. This description does not fit 90% of the offenders referred to Cedar Cottage: only 10% (n = 23) had committed sexual abuse on a single occasion. As is shown in Table 25, these 23 offenders committed 73 abusive acts in the course of those index offences. The proportion of one-off offenders who were declined treatment (12.3%) exceeded that in the group accepted into the program (8.6%). Thus, there was no indication that the screening assessment served to exclude referred offenders whose offending conduct was more serious.

<table>
<thead>
<tr>
<th>Index</th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>18.2</td>
<td>-</td>
<td>8.7</td>
</tr>
<tr>
<td>2</td>
<td>26.7</td>
<td>37.5</td>
<td>-</td>
<td>60.0</td>
<td>36.4</td>
<td>33.3</td>
<td>34.8</td>
</tr>
<tr>
<td>3</td>
<td>6.7</td>
<td>37.5</td>
<td>33.3</td>
<td>40.0</td>
<td>27.3</td>
<td>8.3</td>
<td>17.4</td>
</tr>
<tr>
<td>4</td>
<td>26.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25.0</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>13.3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9.1</td>
<td>16.7</td>
<td>13.0</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>12.5</td>
<td>33.3</td>
<td>-</td>
<td>9.1</td>
<td>-</td>
<td>4.3</td>
</tr>
<tr>
<td>7</td>
<td>-</td>
<td>12.5</td>
<td>33.3</td>
<td>-</td>
<td>-</td>
<td>8.3</td>
<td>4.3</td>
</tr>
<tr>
<td>8</td>
<td>6.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8.3</td>
<td>4.3</td>
</tr>
<tr>
<td>n</td>
<td>15</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
</tbody>
</table>

Most of the 23 offenders referred for a one-off index offence completed two or three abusive acts in the course of that offence. Three offenders referred to Cedar Cottage committed only one abusive act on this occasion, and all three were declined treatment.

Offenders whose index offence entailed sexual abuse on a single occasion were more likely to commit a penetrative (87.0%) than a non-penetrative (13.0%) offence. As is shown in Table 26, most offenders accepted into the program following a single occasion of abuse had committed a penetrative abusive act (91.3%, n= 21).
Table 26. Intrusiveness of abuse in one-off index offences, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonpenetrative</td>
<td>6.7</td>
<td>12.5</td>
<td>33.3</td>
<td>-</td>
<td>18.2</td>
<td>-</td>
<td>8.7</td>
</tr>
<tr>
<td>Penetrative*</td>
<td>93.3</td>
<td>87.5</td>
<td>66.7</td>
<td>100.0</td>
<td>81.8</td>
<td>100.0</td>
<td>91.3</td>
</tr>
<tr>
<td>N</td>
<td>15</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
</tbody>
</table>

* Includes digital and oral penetration and vaginal and anal intercourse. See Table 24 for more detailed information.

In the course of the abuse of the index victim, offenders committed an average of 4.5 types of abusive acts (range 1-10 types of acts). Most offenders completed five different types of abusive acts (16.8%). Results of this analysis, by offender groups, are displayed in Table 27.

Table 27. Number of abusive acts committed during the index offence, by group (percent, number)

<table>
<thead>
<tr>
<th>No. of acts</th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7.4 (9)</td>
<td>2.2 (2)</td>
<td>3.8 (2)</td>
<td>-</td>
<td>5.2 (5)</td>
<td>5.1 (6)</td>
<td>5.1 (11)</td>
</tr>
<tr>
<td>2</td>
<td>19.8 (24)</td>
<td>8.6 (8)</td>
<td>3.8 (2)</td>
<td>15.0 (6)</td>
<td>18.8 (18)</td>
<td>11.9 (14)</td>
<td>15.0 (32)</td>
</tr>
<tr>
<td>3</td>
<td>13.2 (16)</td>
<td>17.2 (16)</td>
<td>13.2 (7)</td>
<td>22.5 (9)</td>
<td>15.6 (15)</td>
<td>14.4 (17)</td>
<td>15.0 (32)</td>
</tr>
<tr>
<td>4</td>
<td>14.9 (18)</td>
<td>16.1 (15)</td>
<td>18.9 (10)</td>
<td>12.5 (5)</td>
<td>14.6 (14)</td>
<td>16.1 (19)</td>
<td>15.4 (33)</td>
</tr>
<tr>
<td>5</td>
<td>16.5 (20)</td>
<td>19.4 (18)</td>
<td>20.8 (11)</td>
<td>17.5 (7)</td>
<td>18.8 (18)</td>
<td>16.9 (20)</td>
<td>17.8 (38)</td>
</tr>
<tr>
<td>6</td>
<td>7.4 (9)</td>
<td>14.0 (13)</td>
<td>15.1 (8)</td>
<td>12.5 (5)</td>
<td>8.3 (8)</td>
<td>11.9 (14)</td>
<td>10.3 (22)</td>
</tr>
<tr>
<td>7</td>
<td>9.9 (12)</td>
<td>12.9 (12)</td>
<td>13.2 (7)</td>
<td>12.5 (5)</td>
<td>10.4 (10)</td>
<td>11.9 (14)</td>
<td>11.2 (24)</td>
</tr>
<tr>
<td>8</td>
<td>9.9 (12)</td>
<td>5.4 (5)</td>
<td>5.7 (3)</td>
<td>5.0 (2)</td>
<td>8.3 (8)</td>
<td>7.6 (9)</td>
<td>7.9 (17)</td>
</tr>
<tr>
<td>9</td>
<td>-</td>
<td>3.2 (3)</td>
<td>3.8 (2)</td>
<td>2.5 (1)</td>
<td>-</td>
<td>2.5 (3)</td>
<td>1.4 (3)</td>
</tr>
<tr>
<td>10</td>
<td>-</td>
<td>1.1 (1)</td>
<td>1.9 (1)</td>
<td>-</td>
<td>-</td>
<td>0.8 (1)</td>
<td>0.5 (1)</td>
</tr>
<tr>
<td>N</td>
<td>120</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>117</td>
<td>213</td>
</tr>
</tbody>
</table>

Analyses of victim and offender statements recorded during the assessment period revealed that offenders who were accepted into the program committed a significantly wider range of abusive acts in the commission of the index offence than did offenders who were declined treatment [Mean number of abusive acts = 4.89 vs. 4.26; \(t (211) = -2.22, d = 0.31\)]. No significant differences emerged in the number of abusive acts committed by treatment completers versus noncompleters.

With respect to the severity of the abuse committed by offenders, results showed that a clear majority of offenders had committed penetrative abuse (83.6%). As shown in Table 28, penetrative offences included oral abuse by offender, oral penetration of the victim, digital penetration, and vaginal and anal intercourse.

Only one offender, who was declined entry, was referred to Cedar Cottage with a non-contact offence as the most severe form of abusive conduct (exposing/exhibiting). Biological fathers were less likely to commit penetrative abuse than were nonbiological fathers. Similarly, offenders declined treatment were less likely to have committed penetrative abuse than those accepted for treatment. None of the differences between groups displayed in Table 28 were statistically significant.
Table 28. Most intrusive sexual abuse, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contact</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.8</td>
</tr>
<tr>
<td>Sexual touching</td>
<td>14.9</td>
<td>16.1</td>
<td>18.9</td>
<td>12.5</td>
<td>19.8</td>
<td>11.9</td>
<td>15.4</td>
</tr>
<tr>
<td>Penetration*</td>
<td>83.5</td>
<td>83.9</td>
<td>81.1</td>
<td>87.5</td>
<td>80.2</td>
<td>86.4</td>
<td>83.6</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>120</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>117</td>
<td>213</td>
</tr>
</tbody>
</table>

* Includes digital and oral penetration and vaginal and anal intercourse. See Table 24 for detailed information.

As is shown in Figure 10, penetrative abuse was more common than sexual touching or no-contact offences, irrespective of the age of the victim. This figure conveys that only one fifth (19.4%) of the offenders whose victims were under five years of age committed a form of nonpenetrative abuse.

**Figure 10. Intrusiveness of abuse by age of youngest victim.**

Finally, to explore whether the assessment procedures implemented at Cedar Cottage favoured intrafamilial offenders who tended to commit only one type of abusive behaviour, an analysis was conducted on the number of offenders whose index offence was limited to a single type of abusive conduct. In all, a small group, 5.1% (n=11) of the offenders, were identified with this profile: five were referred for sexual touching of the victim, one for exposing himself to the victim, one for vaginal intercourse, two for oral abuse of the victim, and two for anal intercourse. Two of these offenders were accepted into the program: both were referred for sexually touching the victim, and both went on to complete treatment successfully.

As noted above, one criterion for admission to Cedar Cottage is the absence of violence in the commission of the index offence. To examine the extent to which this criterion was applied in practice, an analysis was conducted on violence reported during the assessment phase regarding the perpetration of the index offence. The results revealed that the incidence of violence beyond what was necessary to secure the victim’s compliance was very low (2.3%). However, 1 in 5 offenders used threats of force or actual force on their victims. The treatment records for victims reflected that they were most likely to suffer minor physical injury as a result of the abuse, i.e., injuries requiring minimal medical care.
In very few instances, 6.2% of cases, the victim may have required medical care for a moderately serious physical injury at a hospital, but was not required to stay in hospital overnight.

Victims of offenders who were declined treatment were more likely to sustain moderate physical injury than victims of offenders accepted for treatment (9.1% vs. 2.2%), although this difference was not statistically significant. No other differences between offender groups were statistically significant. No mention of the nature of the victim’s injuries was made in a substantial number of the files (46%), as noted in Table 29. The extensive lapse of time between the date of the index offence and date of referral to Cedar Cottage—an average of three years, contributed to the lack of information on this topic.

Table 29. Severity of physical injury to victims, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>41.3</td>
<td>49.5</td>
<td>45.3</td>
<td>55.0</td>
<td>47.9</td>
<td>42.4</td>
<td>45.5</td>
</tr>
<tr>
<td>Moderate</td>
<td>9.1</td>
<td>2.2</td>
<td>1.9</td>
<td>2.5</td>
<td>5.2</td>
<td>6.8</td>
<td>6.2</td>
</tr>
<tr>
<td>Substantial</td>
<td>2.5</td>
<td>2.2</td>
<td>1.9</td>
<td>2.5</td>
<td>1.0</td>
<td>3.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Insufficient</td>
<td>44.6</td>
<td>46.2</td>
<td>50.9</td>
<td>40.0</td>
<td>45.8</td>
<td>47.5</td>
<td>46.0</td>
</tr>
<tr>
<td>information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

The majority of the participants (70.5%) resorted to extortion or threats to secure compliance from the victims, rather than threats of physical violence. (A common term in the literature on this topic is “bribes” which implicates the victim in accepting a bribe. The term “extortion” more precisely depicts the coercive techniques used by program participants.) Types of coercive tactics employed by offender group are displayed in Table 30.

Table 30. Use of physical violence or threats to commit abuse, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No physical force; possible</td>
<td>40.5</td>
<td>32.3</td>
<td>34.0</td>
<td>30.0</td>
<td>42.7</td>
<td>32.2</td>
<td>36.9</td>
</tr>
<tr>
<td>possible extortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats/intimidation not of</td>
<td>27.3</td>
<td>41.9</td>
<td>41.5</td>
<td>42.5</td>
<td>32.3</td>
<td>34.7</td>
<td>33.6</td>
</tr>
<tr>
<td>physical violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat of/actual physical</td>
<td>19.8</td>
<td>21.5</td>
<td>20.8</td>
<td>22.5</td>
<td>17.7</td>
<td>22.9</td>
<td>20.6</td>
</tr>
<tr>
<td>force</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence beyond what was</td>
<td>2.5</td>
<td>2.2</td>
<td>3.8</td>
<td>-</td>
<td>1.0</td>
<td>3.4</td>
<td>2.3</td>
</tr>
<tr>
<td>necessary to secure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient information</td>
<td>9.9</td>
<td>2.2</td>
<td>-</td>
<td>5.0</td>
<td>6.3</td>
<td>6.7</td>
<td>6.6</td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

Information about the degree of psychological injury sustained by victims was less readily available than information about physical injuries, no doubt because of the lengthy lapse of time between the
offence and the referral to Cedar Cottage, compounded by the less visible nature of most psychological injuries. Two-thirds of the files lacked sufficient information on this topic, so the results are tentative. Notwithstanding the lapse of time, the proportion of victims in all treatment groups noted to have experienced substantial or very extensive psychological injuries was more than five times that of victims who experienced substantial physical injuries (13.5 vs. 2.5%). As is shown in Table 31, approximately one half of the victims experienced more severe psychological outcomes requiring ongoing treatment or therapy, and one half required some follow-up counselling, but not ongoing or regular therapy (minor or moderate psychological injury).

Table 31. Severity of psychological injury to the victim, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor/Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substantial/extensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>96</td>
<td>118</td>
<td>214</td>
</tr>
</tbody>
</table>

Acceptance of responsibility following treatment

A key component of the Cedar Cottage Treatment program is acceptance of responsibility for the offending conduct by the offenders. To explore the extent to which acceptance of responsibility is related to reoffending behaviours, offenders’ descriptions of their index offences were coded towards the end of their treatment with Cedar Cottage based on the level of responsibility for the offending reflected in these statements. Three levels of responsibility were distinguished: (a) accepts responsibility for the offence; (b) accepts partial responsibility for the offence (e.g., states that he committed the offence but cites mitigating factors); or (c) fails to accept responsibility for the offence (e.g., claims he was seduced, that the victim enjoyed the assault, or denies the offence). This information was coded only for offenders accepted into the program.

At the point of their last contact with Cedar Cottage, offenders who completed the treatment program were twice as likely to accept full responsibility for their abusive behaviour as noncompleters (92.5% vs. 47.5%) ($\chi^2 = 20.1$, df= 2, N= 90). Biological and nonbiological fathers demonstrated similar levels of acceptance of responsibility. Only one offender failed to accept any degree of responsibility for his abusive behaviour. The results for all offender groups are displayed in Table 32 and Figure 11.

Table 32. Acceptance of responsibility by offenders following treatment, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepts responsibility</td>
<td>92.5</td>
<td>47.5</td>
<td>70.5</td>
<td>75.5</td>
<td>73.1</td>
</tr>
<tr>
<td>Accepts partial responsibility</td>
<td>7.5</td>
<td>42.5</td>
<td>27.3</td>
<td>18.4</td>
<td>22.6</td>
</tr>
<tr>
<td>Fails to accept responsibility</td>
<td>-</td>
<td>2.5</td>
<td>2.3</td>
<td>-</td>
<td>1.1</td>
</tr>
<tr>
<td>Missing</td>
<td>-</td>
<td>7.5</td>
<td>-</td>
<td>6.1</td>
<td>3.2</td>
</tr>
</tbody>
</table>
Face-ups
A further indicator of the acceptance of responsibility for the abusive conduct is participation in face-ups. Offenders who are accepted into the program must prepare a series of face-ups which are prepared for or delivered to the non-offending parent, child victim, other children and family members or friends. The number of face-ups each offender prepared and the person for whom they were intended or presented was recorded in treatment case records. This information was missing for five offenders: two biological and three nonbiological fathers.

All offenders who completed the program provided a face-up to the nonoffending parent, whereas only 57.5% of the noncompleters did so. To be coded as a “face-up”, the presentation had to be delivered to the intended recipient. This conservative definition may have influenced these figures, as some offenders may have prepared face-ups, but not delivered them.

Table 33. Face-ups in treatment by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Biological</th>
<th>Nonbiological</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonoffending parent</td>
<td>100.0</td>
<td>57.5</td>
<td>79.5</td>
<td>83.7</td>
<td>81.7</td>
</tr>
<tr>
<td>Child victim</td>
<td>88.7</td>
<td>30.0</td>
<td>61.4</td>
<td>65.3</td>
<td>63.4</td>
</tr>
<tr>
<td>Child victim’s siblings</td>
<td>92.5</td>
<td>50.0</td>
<td>72.7</td>
<td>75.5</td>
<td>74.2</td>
</tr>
<tr>
<td>Others**</td>
<td>75.5</td>
<td>40.0</td>
<td>56.8</td>
<td>63.3</td>
<td>60.2</td>
</tr>
</tbody>
</table>

* Sum exceeds 100% as offenders could deliver multiple face-ups to the same recipient
**Offender’s parents, partner, siblings, friends, etc.

Face-ups prepared throughout treatment were further assessed in terms of the degree to which they matched the victim’s statement, and whether they contained more detail than the victim had initially disclosed. As is shown in Figure 12, statements by treatment completers were significantly more likely to match the scope of the victims’ disclosure (χ² = 11.3, df= 1, N= 91) and to provide additional details and information (χ² = 10.3, df= 1, N= 91) than statements by treatment noncompleters. Differences
between victim and offender statements by biological versus nonbiological fathers were not statistically significant.

Figure 12. Victim and offender accounts of offending, by group (percent)

Comparison of offenders referred before and after 1993

The distribution of offenders across groups did not differ significantly before and after the legislative amendments in 1993 (see Table 34). Interestingly, all offenders who voluntarily withdrew from the treatment program (8.6%, n=8) did so after the legislative changes were implemented (1993-2007).

Table 34. Comparisons of groups before and after April, 1993 (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>Pre-amendment</th>
<th>Post-amendment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined</td>
<td>61.8 (47)</td>
<td>53.6 (74)</td>
</tr>
<tr>
<td>Accepted</td>
<td>38.2 (29)</td>
<td>46.4 (64)</td>
</tr>
<tr>
<td>Completed</td>
<td>25.0 (19)</td>
<td>24.6 (34)</td>
</tr>
<tr>
<td>Breached</td>
<td>13.2 (10)</td>
<td>15.9 (22)</td>
</tr>
<tr>
<td>Withdrew</td>
<td>0.0 (0)</td>
<td>5.8 (8)</td>
</tr>
<tr>
<td>Biological</td>
<td>46.1 (35)</td>
<td>44.2 (61)</td>
</tr>
<tr>
<td>Nonbiological</td>
<td>53.9 (41)</td>
<td>55.8 (77)</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>138</td>
</tr>
</tbody>
</table>

The pre- and post-amendment groups rarely differed on any of the investigated variables: no significant differences emerged regarding time in treatment, Aboriginal status, relationship to victim, employment history and age of offender at first abuse. Significantly more offenders in the post-amendment group were in a common law (25.7% vs. 14.5%), than in a legal marriage (54.4% vs. 81.6%) ($\chi^2 = 18.317$, df= 5, N= 212).

Fewer offenders admitted in the post-amendment period had a substance abuse history (29.2% vs. 9.3%); more substance abuse was reported that was unrelated to the offence (25.5% vs. 16.0%), however these differences were not statistically significant. The proportion of files containing insufficient information for these comparisons dropped significantly from 54.7% to 25.5% ($\chi^2 = 22.085$, df= 3, N= 212).
Among the offenders admitted following the amendments, fewer reported a childhood history of sexual abuse (28.9% vs. 5.5% reporting no history; $\chi^2 = 40.75$, df = 3, N = 208), physical and/or emotional abuse (30.8% vs. 17.9%; $\chi^2 = 32.78$, df = 3, N = 200). When cases with missing information were excluded, these differences remained significant ($\chi^2 = 9.45$, df = 2, N = 132 for sexual abuse; $\chi^2 = 7.31$, df = 2, N = 112 for physical and emotional abuse). More complete data were available after 1993 (22.2% vs. 63.0% cases with insufficient information for sexual abuse, 30.8% vs. 70.1% for physical and/or emotional abuse).

### Table 35. Prior criminal and sexual offences before and after April, 1993 (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>Criminal offences</th>
<th>Sexual offences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report Conviction</td>
<td>Report Conviction</td>
</tr>
<tr>
<td>Pre-amendments</td>
<td>50.0 (38) 38.2 (29)</td>
<td>11.8 (9) 2.6 (2)</td>
</tr>
<tr>
<td>Post-amendments</td>
<td>57.2 (79) 49.3 (68)</td>
<td>10.9 (15) 5.8 (8)</td>
</tr>
</tbody>
</table>

As shown in Table 35, rates of prior criminal conduct were similar in the offender groups before and after the legislative amendments. Fifteen offenders in the pre-amendment group (19.7%) had a history of juvenile offending versus 25 (18.1%) in the post-amendment group. Although the number of offenders referred with a juvenile history of sex offending increased following the amendments (2 vs. 7, 2.6% vs. 5.1%), the increase was not statistically significant. Comparisons by type of offence did not yield statistically significant differences. These results are displayed in Table 36.

### Table 36. Official reports and convictions for prior offences before and after April, 1993 (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>Non-contact offences</th>
<th>Indecent assault</th>
<th>Sexual assault</th>
<th>Violent offences</th>
<th>Breach AVO</th>
<th>NSNV offences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rep Conv Rep Conv Rep Conv Rep Conv Rep Conv Rep Conv Rep Conv Rep Conv</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-amendments</td>
<td>0.0 0.0 1.3 1.3 11.8 2.6 10.5 5.3 1.3 0.0 39.5 35.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-amendments</td>
<td>2.2 2.2 6.5 2.9 2.9 1.4 24.6 19.6 4.3 2.9 45.7 42.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AVO = Apprehended violence order; NSNV = Nonsexual nonviolent offence

In the period after April, 1993, characteristics of victims did not differ, neither did general characteristics of index offences (numbers of charges, number of incidents and mean duration of offence). The rate of reports of exposure/exhibition increased significantly among offenders admitted to Cedar Cottage after April, 1993 (57.7% vs. 27.6%; $\chi^2 = 17.7$, df = 1, N = 213). Following the amendments, more coercion by offenders in the form of threats and intimidation was reported (38.7% vs. 25.0%), but fewer offenders used threats of or actual force (19.0% vs. 23.7%; $\chi^2 = 10.23$, df = 4, N = 213). A bivariate correlation between psychological harm and date of referral (before vs. after April, 1993) was statistically significant (Kendall’s T = .237), indicating that more psychological harm was reported by victims after 1993, however almost half of the files lacked information on this topic.

Acceptance of responsibility was high among completers in both time periods (75.0% respectively), and the number of face-ups prepared during treatment was similar. Significantly more face-ups were
presented to others during treatment (67.2% vs. 42.4%; \( \chi^2 = 5.51, \text{df} = 1, N = 97; \) N refers to the number of face-ups presented) after the 1993 amendments.

**Summary**

The rigorous comparisons of the offenders accepted for treatment with those in the declined control group yielded few differences, establishing important foundational equivalence between the groups to test whether the treatment program effectively reduced recidivism. Further comparisons established that offenders referred to the program before and after the legislative amendments implemented in April, 1993 did not differ on major demographic variables of interest, victim characteristics, index offence characteristics and acceptance of responsibility for their offending behaviour.

A comprehensive analysis of the characteristics of the offenders, index offences and victims provided fresh insights into the nature of intrafamilial child sexual offending. These evaluation outcomes are helpful in demystifying several aspects of intrafamilial sex offending and in developing a more comprehensive portrait of the types of abusive conduct in issue, the duration of the offences, and the consequences for victims. These findings provide valuable practical guidance for crime prevention and law enforcement, for future planning and policy development regarding community-based and institutional treatment programs and sentencing.
CHAPTER 7
RECIDIVISM FOLLOWING REFERRAL TO CEDAR COTTAGE

Reoffence rates observed in official police reports and convictions ....................................................... 88
Observed rates of sexual and nonsexual reoffending.............................................................................. 90
Relative reduction in sexual recidivism rates ........................................................................................... 92
Length of time before relapse (survival analysis)..................................................................................... 93
Relationship to victim ............................................................................................................................... 97
Fewer victims of reoffences ..................................................................................................................... 97
Fewer reoffences...................................................................................................................................... 98
Less harmful reoffending conduct ............................................................................................................ 99
Prior offending........................................................................................................................................ 101
STATIC-99 scores and recidivism ............................................................................................................ 103
Acceptance of responsibility and recidivism .......................................................................................... 103
Summary ................................................................................................................................................ 104
CHAPTER 7

RECIDIVISM FOLLOWING REFERRAL TO CEDAR COTTAGE

To obtain the most accurate estimates of recidivism possible, reoffence rates for the study sample were derived from three official data sources in New South Wales: NSW Police, NSW BOCSAR and NSW Dept of Corrective Services. Two measures of reoffending following an offender’s last contact with Cedar Cottage were used: (a) official police intelligence reports of reoffending—in the form of arrests, apprehensions, charges and other intelligence information, and (b) records of convictions. Both measures are conservative but reliable indicators of recidivism. All recidivism data cited in this report for the study sample are derived from actual observed reoffences documented in these official records.

Given that the Cedar Cottage treatment intervention aims to reduce sexual reoffending, the major variable of interest was relapses and reoffences of a sexual nature. All reoffences were distinguished as sexual or nonsexual. Three categories of re offending behaviour are reported: (a) sexual reoffending rates, (b) nonsexual reoffending rates and (c) general or overall reoffence rates derived from a combined total of sexual and nonsexual reoffences.

The focus of the recidivism analyses was a comparison of reoffending behaviours by offenders in the group diverted to the community-based treatment program with that of offenders in the control group who were declined treatment and who experienced traditional criminal sentencing procedures and sanctions. Where relevant, we compared outcomes for offenders who completed the treatment program at Cedar Cottage with those the noncompleters who dropped out of the treatment program.

Reoffending data for all 214 offenders referred to Cedar Cottage in the period 1989–2003 were analysed in several different ways to develop a more comprehensive understanding of the effects of the Cedar Cottage treatment program on recidivism:

- Absolute rates of sexual, nonsexual and overall recidivism
- Relative reductions in sexual, nonsexual and overall recidivism
- Length of time before first relapse (survival analysis)
- Predictors of reoffending (logistic regression)
- Numbers of victims of sexual recidivists
- Numbers of offences committed by recidivists
- Severity of sexual reoffences committed by recidivists

The observation period for recidivism following an offender’s last contact with Cedar Cottage ranged from 3.8 to 18 years. All results reported include the entire sample referred to Cedar Cottage between 1989 and 2003. Recidivism rates by offenders referred after the legislative amendments in April, 1993 are included in each section, following the overall findings.
Reoffence rates observed in official police reports and convictions

Rates of reoffending derived from the official police intelligence reports were compared with those derived from conviction records to explore the extent of the gap between these two official sources of information. As in the case of the analyses of the prior criminal history of offenders, substantial differences emerged from these two different indicators of recidivism: one-third (30%) of the official reports of reoffending conveyed to police were missed when only official convictions were counted. A comparison of absolute rates of offending behaviour observed in official police reports versus convictions is displayed in Table 37, by type of offence, for all offender groups of interest.

Table 37. Recidivism rates from official reports and convictions 1989-2007, by group (percent)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rep</td>
<td>Conv</td>
<td>Rep</td>
<td>Conv</td>
</tr>
<tr>
<td>Overall recidivism</td>
<td>19.2</td>
<td>14.5</td>
<td>11.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>7.5</td>
<td>1.9</td>
<td>3.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Non-contact offence</td>
<td>4.2</td>
<td>0.9</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Indecent assault</td>
<td>4.2</td>
<td>0.9</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>2.3</td>
<td>0.0</td>
<td>1.4</td>
<td>0.9</td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>11.7</td>
<td>9.3</td>
<td>8.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Nonviolent offence</td>
<td>8.4</td>
<td>7.0</td>
<td>6.1</td>
<td>5.1</td>
</tr>
<tr>
<td>Violent offence</td>
<td>2.3</td>
<td>1.4</td>
<td>3.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Breach AVO</td>
<td>3.3</td>
<td>2.3</td>
<td>0.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Rep = official police report of reoffending conduct; Conv = conviction of reoffence
Note: Percentages are calculated for entire sample (N=214). Proportion and number of the subset of sexual and nonsexual offences does not equal the total percent/N for each group as some offenders committed multiple sexual and nonsexual offences (e.g., violent and nonsexual, nonviolent reoffences).

Some offenders in all groups were less likely to come to the attention of police during the period following the imposition of criminal sanctions for the index offence, than they were prior to referral to the program.

Analyses at the level of official police reports revealed that approximately 3 out of every 10 offenders engaged in some type of criminal conduct after sentencing for the index offence. The overall reoffence rate for all offenders in the study sample using this measure was 30.8%, or 3 out of every 10. By comparison, when conviction rates were used as the indicator of recidivism, the overall reoffence rate was approximately 1 in 5 or 21.5%). Most reoffences committed (15-19%) were nonsexual and nonviolent in nature.

As program participants near the completion of their treatment, where there is concern for the future safety of the victim, most typically in families where no reunification is likely and no subsequent contact between the victim and the offending parent is desired, in the context of discussions over safety, Cedar Cottage staff recommend that the family consider an Apprehended Violence Order (AVO) against the offender as part of their planning. No offender accepted for treatment was convicted for any breach of an AVO, and only one offender who dropped out of treatment was reported for a possible AVO breach following his last date of contact with Cedar Cottage. As is shown in Table 37, seven offenders in the declined group were reported for or convicted for breaching an AVO.

A comparison of rates of sexual reoffending in official reports versus convictions revealed some marked disparities. For example, the rate of non-contact sexual offending observed in official police reports...
(6.1%) was six times that observed in convictions (0.9%), and the rate of sexual assault reoffences in official reports was four times that observed in conviction data (3.7% versus 0.9%). With the low reoffending data derived from the conviction rates, differences between the target groups are more difficult to discern, precluding interferences about trends in the data and the effectiveness of the treatment intervention. Since the major purpose of this evaluation was to examine the scope of sexual relapses and reoffending rather than reconviction rates per se, and the more comprehensive and sensitive indicator of sexual reoffending was the less stringent official police records, the official police reports of criminal reoffending were used as the indicator event for all subsequent recidivism analyses.

Logistic regression analyses revealed no significant influence of the offender-victim relationship on rates of reoffending, as is evident in the average rates of reoffending for biological and nonbiological fathers displayed in Table 38.

Table 38. Recidivism rates from official reports and convictions (percent) by offence type and offender relationship to victim

<table>
<thead>
<tr>
<th></th>
<th>Biological Report</th>
<th></th>
<th>Convictions</th>
<th></th>
<th>Nonbiological Report</th>
<th></th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall recidivism</td>
<td>13.1</td>
<td>9.3</td>
<td>17.8</td>
<td>12.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>5.6</td>
<td>2.3</td>
<td>5.1</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-contact offence</td>
<td>3.3</td>
<td>0.5</td>
<td>2.8</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indecent assault</td>
<td>3.3</td>
<td>1.9</td>
<td>2.3</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual assault</td>
<td>2.3</td>
<td>0.5</td>
<td>1.4</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>7.5</td>
<td>5.6</td>
<td>12.6</td>
<td>9.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonviolent offence</td>
<td>5.1</td>
<td>4.2</td>
<td>9.3</td>
<td>7.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent offence</td>
<td>3.3</td>
<td>1.4</td>
<td>2.3</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breach AVO</td>
<td>0.5</td>
<td>0.5</td>
<td>3.3</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total known number of victims of sexual recidivism</td>
<td>29</td>
<td>11</td>
<td>12</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Percentages are calculated for entire sample (N=214). Proportion and number of the subset of sexual and nonsexual offences does not equal the total percent/N for each group as some offenders committed multiple sexual and nonsexual offences (e.g., violent reoffences and nonsexual, nonviolent reoffences).

The rates of sexual reoffending reported above make no distinction between child sexual reoffences, i.e., reoffending involving abuse of a minor under the age of 18 years, and sexual reoffences that do not. An analysis of those data by group is displayed in Table 39.

Table 39. Recidivism rates from official reports (percent) by age of youngest victim and treatment group

<table>
<thead>
<tr>
<th>Victim Age</th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
<td>37.5</td>
<td>42.9</td>
<td>25.0</td>
<td>66.7</td>
</tr>
<tr>
<td>5-10 years</td>
<td>18.8</td>
<td>14.3</td>
<td>0.0</td>
<td>33.3</td>
</tr>
<tr>
<td>11-16 years</td>
<td>37.5</td>
<td>28.6</td>
<td>50.0</td>
<td>0.0</td>
</tr>
<tr>
<td>17 years and over</td>
<td>6.3</td>
<td>14.3</td>
<td>25.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total N</td>
<td>16</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
Throughout the remainder of this report, all reported sexual reoffence rates are defined at the most inclusive level, i.e., reoffending includes sexual reoffences with adults, extrafamilial sex offences as well as intrafamilial sex offending.

**Observed rates of sexual and nonsexual reoffending**

Using official police reports as the indicator event for recidivism, the overall recidivism rate, the sexual recidivism rate and the nonsexual recidivism rates for offenders who were declined treatment, exceeded the rates of reoffending observed in all three of these categories for the group of offenders accepted for treatment. Binary logistic regression analyses revealed these differences were not statistically significant. The overall reoffence rate for treatment completers fell between 1 in 4 or 1 in 5 (22.6%) and was substantially lower than that observed for noncompleters: 1 in 3 (32.5%). The reoffence rate for sexual offending in the group declined treatment was approximately twice as high as that observed in the group accepted for treatment. The rate of nonsexual recidivism in the group accepted for treatment dropped by 8 per cent compared to that in the group declined treatment. These outcomes are displayed in Table 40 along with the number of offenders in each group whose reoffending conduct was the subject an official police report.

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>No recidivism</td>
<td>66.1</td>
<td>(80)</td>
<td>73.1</td>
<td>(68)</td>
<td>77.4</td>
</tr>
<tr>
<td>Overall recidivism</td>
<td>33.9</td>
<td>(41)</td>
<td>26.9</td>
<td>(25)</td>
<td>22.6</td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>13.2</td>
<td>(16)</td>
<td>7.5</td>
<td>(7)</td>
<td>7.5</td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>20.7</td>
<td>(25)</td>
<td>19.4</td>
<td>(18)</td>
<td>15.1</td>
</tr>
<tr>
<td>Total N</td>
<td>121</td>
<td>93</td>
<td>53</td>
<td>40</td>
<td>214</td>
</tr>
</tbody>
</table>

Of the 23 offenders who reoffended sexually, the relationship between the offender and victim was unknown for seven offenders. A total of 10 of the 16 sexual reoffenders where this relationship was known reoffended intrafamilially; six reoffended extrafamilially. Of the intrafamilial reoffenders, six were declined treatment, two were treatment completers and two were noncompleters. Although the number of offenders who sexually reoffended was too small to permit significance tests, the available data revealed that more than one quarter of the reoffenders (26.1%) reoffended extrafamilially. The numbers are too small to make reliable estimates of the proportion of intrafamilial sex offenders who also commit extrafamilial sex offences, but this finding clearly demonstrates that a substantial proportion of these intrafamilial sex offenders did not confine their offending to close family members.

After Cedar Cottage had been in operation for approximately four years, following the legislative amendments and program changes implemented in April, 1993, the observed rates of overall, sexual and nonsexual recidivism for all offenders accepted into the program declined even further. However, these differences were not statistically significant. Notably, comparisons of reoffence rates before and after these changes revealed that the rate of sexual reoffending after April 14, 1993 declined the most sharply, from 14.5% (n = 11) to 8.7% (n=12), as is shown in Table 41.
Table 41. Overall, sexual and nonsexual recidivism before and after April, 1993 (percent, number)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall recidivism</td>
<td>34.2 (26)</td>
<td>29.0 (40)</td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>14.5 (11)</td>
<td>8.7 (12)</td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>19.7 (15)</td>
<td>20.3 (28)</td>
</tr>
<tr>
<td>N</td>
<td>76</td>
<td>138</td>
</tr>
</tbody>
</table>

To further explore the source of these changes, the recidivism rates in the groups declined and accepted for treatment were compared. The results of these analyses indicated that changes in the behaviours of the offenders who were accepted for treatment at Cedar Cottage were responsible for the observed differences. When the estimated lifetime overall, sexual and nonsexual reoffence rates before and after 1993 for offenders in the control group were examined, the results revealed no significant changes. In other words, the reoffence rates among individuals declined treatment who were exposed to traditional criminal sanctions were much the same before and after 1993, as is shown in Table 42. However the reoffence rates for offenders accepted into the program in the period following April, 1993 were reduced in all three categories: overall recidivism rates deceased by 11.1%, sexual recidivism by 9.1% and nonsexual recidivism by 2.0%. The reoffence rates for offenders who completed the program of treatment at Cedar Cottage in the years 1993-2003 dropped even more dramatically: overall recidivism was reduced in this group by 22.1%, sexual recidivism by 12.9% and nonsexual recidivism by 9.3%.

Table 42. Reoffence rates by group before and after 1993 (percent, number)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>All offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reoffence rate before 1993</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reoffence</td>
<td>66.0 (31)</td>
<td>65.5 (19)</td>
<td>63.2 (12)</td>
<td>70.0 (7)</td>
<td>65.8 (50)</td>
</tr>
<tr>
<td>Overall recidivism</td>
<td>34.0 (16)</td>
<td>34.5 (10)</td>
<td>36.8 (7)</td>
<td>30.0 (3)</td>
<td>34.2 (26)</td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>14.9 (7)</td>
<td>13.8 (4)</td>
<td>15.8 (3)</td>
<td>10.0 (1)</td>
<td>14.5 (11)</td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>19.1 (9)</td>
<td>20.7 (6)</td>
<td>21.1 (4)</td>
<td>20.0 (2)</td>
<td>19.7 (15)</td>
</tr>
<tr>
<td>Total N</td>
<td>47</td>
<td>29</td>
<td>19</td>
<td>10</td>
<td>76</td>
</tr>
</tbody>
</table>

| Reoffence rate after 1993 |          |          |           |              |               |
| No reoffence             | 66.2 (49)| 76.6 (49)| 85.3 (29)| 66.7 (20)    | 71.0 (98)     |
| Overall recidivism       | 33.8 (25)| 23.4 (15)| 14.7 (5) | 33.3 (10)    | 29.0 (40)     |
| Sexual recidivism        | 12.2 (9) | 4.7 (3)  | 2.9 (1)  | 6.7 (2)      | 8.7 (12)      |
| Nonsexual recidivism     | 21.6 (16)| 18.7 (12)| 11.8 (4) | 26.7 (8)     | 20.3 (28)     |
| Total N                  | 74       | 64       | 34        | 30           | 138           |

In sum, the first four years of the program (1989-1992) did not seem to have any marked effect on offenders’ reconviction levels: reoffending rates for sexual offences were almost the same for those who entered the program (13.8%) as those who did not (14.9%). This pattern was replicated for overall and nonsexual recidivism. However, from April, 1993 the program did seem to have a major impact on rates of reoffending, and acceptance into the program reduced the reoffence rates for all types of recidivism.
Notwithstanding the absence of statistically significant differences between reoffence rates of offenders accepted into the program and declined, a number of indicators reflected that contact with the Cedar Cottage program reduced reoffence rates. Moreover, when offenders who had contact with the program did relapse, in most cases the reoffending behaviour observed was less egregious than that among offenders who were not exposed to the program. An examination of the nature of the sexual reoffending conduct by offenders who completed the treatment program demonstrates this point.

In all, 14.5% (n=11) of the offenders referred before April 14, 1993 reoffended sexually. Of these, three had successfully completed treatment, one did not complete treatment and seven were declined treatment. After April 1993, of the 12 sexual reoffenders, three were accepted into the program. Only one reoffender had successfully completed treatment, two were noncompleters, and the remaining nine were declined treatment.

In all, a total of 7 of the 93 offenders (7.5%) accepted into the Cedar Cottage treatment program reoffended sexually, four of whom had completed the treatment program. Three of these individuals, Offenders A, B and C were referred for treatment before April, 1993; only Offender D was referred after April, 1993. The reoffending conduct reported in the case of Offender D, consisted of peeping and prying, did not involve a minor, and no charge or conviction resulted.

### Table 43. Sexual reoffences by program completers 1989-2007

<table>
<thead>
<tr>
<th>Referred after April 14, 1993</th>
<th>Date of Completion</th>
<th>Time to reoffend</th>
<th>Relationship to victim</th>
<th>Victim age</th>
<th>Nature of offence (most serious)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>N</td>
<td>15/09/93</td>
<td>2.5 months</td>
<td>Step-daughter (sister of index victim)</td>
<td>11 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Biological daughter</td>
<td>14 yrs</td>
</tr>
<tr>
<td>B</td>
<td>N</td>
<td>30/06/95</td>
<td>2.5 months</td>
<td>Daughter (index victim)</td>
<td>14 yrs</td>
</tr>
<tr>
<td>C</td>
<td>N</td>
<td>16/06/95</td>
<td>8 years 2 months</td>
<td>General public</td>
<td>n/a</td>
</tr>
<tr>
<td>D</td>
<td>Y</td>
<td>31/05/04</td>
<td>7 months</td>
<td>Female colleague</td>
<td>51 yrs</td>
</tr>
</tbody>
</table>

Most notably, the recidivism data for all 138 offenders referred to Cedar Cottage in the period 1993-2004, of whom 64 were accepted for treatment, revealed no official police reports or convictions of any sexual offence against a minor by any of the 34 offenders who completed the treatment program.

### Relative reduction in sexual recidivism rates

As was shown in the foregoing section, exposure to the Cedar Cottage treatment program reduced both sexual and nonsexual absolute recidivism rates. Another way to examine the effectiveness of the treatment on sexual reoffending is to compute the relative reduction in recidivism rates of offenders who were accepted for treatment in comparison with that of offenders who were declined treatment. With respect to sexual recidivism, if we look across the entire study period from 1989-2007, participation in the program reduced reoffending by more than two-fifths (43.2%). The relative
reduction in sexual recidivism from 1993-2007 among participants who were accepted compared to those who were declined treatment, is more dramatic, a reduction of three-fifths (61.5%). In other words, the rate of sexual reoffending among offenders accepted into the program reduced from 1 in 9 to 1 in 20 after 1993.

Relative reductions in nonsexual recidivism were less marked. With respect to nonsexual recidivism, if we look across the entire study period from 1989-2007, participation in the program reduced nonsexual reoffending by less than one-tenth (6.3%). The relative reduction in nonsexual recidivism from 1993-2007 among participants who were accepted compared to those who were declined treatment, was greater (13.4%) but not as dramatic as it was for sexual recidivism.

**Length of time before relapse (survival analysis)**

One measure of the capacity of offenders to desist from reoffending is the period of time they spend in the community before reoffending. To determine whether the treatment program delivered to sex offenders at Cedar Cottage inhibited sexual reoffending by increasing the amount of time that lapsed following treatment and before reoffending commenced, the reoffence data were subjected to survival analysis. For all offenders, the survival period commenced on the date of the offender’s last contact with the program (i.e., assessment completion, treatment completion, breach or withdrawal). Offenders who relapsed while in contact with Cedar Cottage, either during the eight-week period of assessment or during treatment, had a survival period of zero days. In the case of offenders who were incarcerated prior to reoffending, the amount of time spent in custody was subtracted from their survival period, leaving the amount of available time for an offender to reoffend, or “street time,” (Duwe & Donnay, 2008). Failure to make this adjustment could potentially bias the outcomes. However, offenders in the community attending the treatment program received no credit for their “street time” desistance of two to three years before their last contact with Cedar Cottage.

The overall average time to reoffend was three years and three months (range= zero to 11.5 years) (see Table 40). On average, offenders desisted from reoffending sexually and nonsexually for approximately the same period of time (M= 3.69 and 3.72 years respectively). Desistance from reoffending by offenders who were accepted for treatment was increased for overall and for sexual reoffending in comparison with speed at which the declined group reoffended, as is shown in Table 44. The mean estimated period before relapse among offenders accepted into the treatment program exceeded that in the declined group by approximately one year for overall and sexual reoffending. In the case of sexual reoffences, exposure to the treatment program increased offender desistance: the mean estimated relapse period by offenders accepted into the program exceeded that of the declined group by 10.8 months (328 days). The time lapse before nonsexual reoffending in the declined and accepted groups was similar (3.7 years). However, Bonferroni-adjusted independent samples t-tests with alpha levels set at 0.006 revealed no significant differences between any of the groups on time taken to reoffend overall, sexually and nonsexually (Table 44).
Table 44. Average time to reoffend 1989-2007, by group (years)

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Sexual</th>
<th>Non-sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Years</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>3.26</td>
<td>23</td>
</tr>
<tr>
<td>Declined</td>
<td>41</td>
<td>2.94</td>
<td>16</td>
</tr>
<tr>
<td>Accepted</td>
<td>25</td>
<td>3.79</td>
<td>7</td>
</tr>
<tr>
<td>Completed</td>
<td>12</td>
<td>3.72</td>
<td>4</td>
</tr>
<tr>
<td>Noncompleted</td>
<td>13</td>
<td>3.86</td>
<td>3</td>
</tr>
</tbody>
</table>

*Skewed by one offender who recidivated in 8.2 years (3001 days); median time = 4.8 months or 146 days.

A series of Cox proportional hazards regression analyses were conducted to determine the effect of contact with Cedar Cottage on rates of recidivism. This measure makes no assumptions regarding the distribution of the sample. Separate analyses investigated the influence of program acceptance and program completion on overall, sexual and nonsexual reoffending. The results indicated that program acceptance and program completion did not significantly predict the likelihood of overall, sexual and nonsexual reoffending. That is, accepted offenders were not significantly less likely to reoffend compared to declined participants; and program completers were not less likely to reoffend than noncompleters.

Offenders with a prior criminal offence as an adult tended to reoffend nonsexually earlier than offenders with no prior offences, although these differences were nonsignificant. Interestingly, offenders with both a juvenile and an adult criminal history tended to recidivate sexually earlier than offenders with no prior offences and offenders with an adult criminal history only; however this difference was also nonsignificant.

After 1993, the period of desistance before sexual recidivism among offenders accepted for treatment increased by 10.6 months to an average of 5.22 years whereas the period that lapsed before overall reoffending and nonsexual reoffending was unchanged. Nonetheless, Bonferroni-adjusted independent samples t-tests with alpha levels set at 0.006 revealed no significant differences between any of the groups on time taken to reoffend overall, sexually and nonsexually in the period 1993-2007 (Table 45).

Table 45. Average time to reoffend 1993-2007, by group (years)

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Sexual</th>
<th>Non-sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Years</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>2.98</td>
<td>12</td>
</tr>
<tr>
<td>Declined</td>
<td>25</td>
<td>2.74</td>
<td>9</td>
</tr>
<tr>
<td>Accepted</td>
<td>15</td>
<td>3.38</td>
<td>3</td>
</tr>
<tr>
<td>Completed</td>
<td>5</td>
<td>3.62</td>
<td>1</td>
</tr>
<tr>
<td>Noncompleted</td>
<td>10</td>
<td>3.25</td>
<td>2</td>
</tr>
</tbody>
</table>

Cox proportional hazards regressions were also conducted to determine the effect of changes to the program implemented in April, 1993 on the likelihood of reoffending sexually, nonsexually or overall (using survival analysis). The 76 offenders referred before April 1993 were excluded from a series of
Cox proportional hazards regression analyses conducted to address these questions. As in the case of offenders referred in all years in the study period, the results indicated that program acceptance did not significantly predict the likelihood of overall, sexual and nonsexual reoffending in the period 1993-2003 (See Figures 14-16). However, these analyses revealed a marginally significant effect of program completion on the likelihood of overall recidivism ($\chi^2 = 3.04$, df= 1, N= 74, Wald statistic = 2.84, $p=.08$). Offenders who did not complete the treatment program were 2.5 times more likely to recidivate overall than were offenders who completed the treatment program (see Figure 13). Program completion did not significantly predict the likelihood of sexual or nonsexual reoffending between 1993-2007.

**Figure 13. Overall recidivism survival 1993-2007, in program completion groups**

![Figure 13](image1)

**Figure 14. Overall recidivism survival 1993-2007, in declined and accepted groups**

![Figure 14](image2)
The foregoing figures and an inspection of the mean period of time to reoffend following exposure to the treatment program showed that offenders who had contact with Cedar Cottage survived for a longer period without relapsing than did their counterparts who experienced traditional criminal sanctions. This evidence of desistance is another important aspect of harm minimization to consider in evaluating the success of the treatment intervention.
**Relationship to victim**

Cox proportional hazards regression analyses (survival analysis) were conducted to investigate whether the relationship between the offender and victim predicted likelihood of reoffending. The results indicated that offender relationship to the victim did not significantly predict the likelihood of overall, sexual and nonsexual reoffending in the period 1989-2003 (see Table 46). That is, biological and nonbiological fathers reoffended at a similar rate in that period.

| Table 46. Offender relationship with victim and rate of recidivism (percent, number) |
|---------------------------------|-----------------|-----------------|-----------------|
|                                | Overall recidivism | Sexual recidivism | Nonsexual recidivism |
|                                | Total N           | n          | %      | Years | n          | %      | Years | n          | %      | Years |
| Biological father              | 96               | 28        | 29.2   | 4.2   | 12        | 12.5   | 4.0   | 16        | 16.7   | 5.2   |
| Nonbiological father           | 118              | 38        | 32.2   | 2.6   | 11        | 9.3    | 3.4   | 27        | 22.9   | 2.0   |

Additional survival analyses were also conducted to determine the effect of changes to the program implemented in April, 1993 on the likelihood of reoffending sexually, nonsexually or overall. The 76 offenders referred before April 1993 were excluded from a series of Cox proportional hazards regression analyses conducted to address these questions. As in the case of offenders referred in all years in the study period, the results indicated that offender relationship to victim did not significantly predict the likelihood of overall, sexual and nonsexual reoffending in the period 1993-2003.

Examination of the time taken to reoffend following the last contact with Cedar Cottage revealed that on average, biological fathers recidivated more rapidly than did nonbiological fathers with respect to both sexual and nonsexual offences. However, there was no significant difference between biological and nonbiological fathers on time to reoffend generally (overall) or sexually in the period 1993-2007. Results of a series of Bonferroni adjusted independent t-tests (alpha = .006) revealed a marginally significant result for time taken to reoffend nonsexually \( t(26) = -2.82, p=.009, d = 1.13 \). That is, biological fathers referred after April 1993, took substantially longer to reoffend nonsexually (mean years = 5.2) than nonbiological fathers (mean years = 2.0).

**Fewer victims of reoffences**

The number of victims of sexual recidivism identified in official reports was substantially higher than that identified in official convictions: 3.2 times more victims were identified in reports (41 vs. 13 victims). Thus 28 known victims were excluded when convictions only were taken into account. Information about the number of victims of sexual recidivism was not available for 6 of the 23 offenders who sexually reoffended (see Table 47).

<table>
<thead>
<tr>
<th>Table 47. Number of victims of sexual recidivism, by group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined</td>
</tr>
<tr>
<td>Rep</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Known number of victims</td>
</tr>
</tbody>
</table>

Rep = official report of reoffence; Conv = conviction for reoffence
A similar analysis of victims of sexual reoffences by biological versus nonbiological fathers revealed that although the reoffence rates by biological and nonbiological fathers were similar (see Table 48 below), reoffences by biological fathers impacted far more individual victims than did reoffences by nonbiological fathers. This was one aspect of offending behaviour on which these two groups differed.

Table 48. Number of victims of sexual recidivism by biological and nonbiological fathers

<table>
<thead>
<tr>
<th>Known number of victims of sexual recidivism</th>
<th>Biological Report</th>
<th>Conviction</th>
<th>Nonbiological Report</th>
<th>Conviction</th>
<th>Total Report</th>
<th>Conviction</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>11</td>
<td>12</td>
<td>2</td>
<td>13</td>
<td>41</td>
<td>13</td>
</tr>
</tbody>
</table>

The cohort of 76 offenders referred to Cedar Cottage before April, 1993 in the first four years of the operation of the program included 8 sexual reoffenders about whom victim data were available. They reoffended against 25 victims. The larger cohort of 138 offenders referred in the period April 1993 through 2003 included 9 sexual reoffenders about whom victim data were available. They reoffended against 16 victims. In the early years, there was a difference between the number of victims of declined and accepted groups (22 vs. 3 victims). In the period after April, 1993, the number of victims of reoffences by the declined group was 12 versus 4 victims in the accepted group. Thus, this indicator confirmed that the harm inflicted by offenders exposed to the treatment program was substantially reduced in the period 1993-2007.

**Fewer reoffences**

Offenders who reoffended either sexually or nonsexually committed between 1 and 19 reoffences, although one outlier committed 64 nonsexual reoffences. The mean number of offences in the total sample was five reoffences overall, two sexual and four nonsexual reoffences (see Table 49). Offenders declined entry to the program committed more reoffences overall than offenders accepted into the program. Program completers committed a similar number of overall reoffences to program noncompleters; but completers tended to commit more nonsexual reoffences. Bonferroni-adjusted independent samples t-tests with alpha levels set at 0.008 revealed no significant differences in the number of overall, sexual and nonsexual reoffences based on acceptance into the program or treatment completion.

These trends were reversed in the period April 1993–2007: offenders accepted into the program tended to commit more nonsexual reoffences than offenders declined entry; declined offenders tended to commit more sexual reoffences. Program completers committed a similar number of sexual reoffences to program noncompleters; but noncompleters tended to commit more nonsexual reoffences. Bonferroni-adjusted independent samples t-tests with alpha levels set at 0.008 revealed no significant differences in the number of overall, sexual and nonsexual reoffences based on acceptance into the program or treatment completion in the period 1993-2007.
Table 49. Number of overall, sexual and nonsexual reoffences, by group (mean)

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>Accepted</th>
<th>Completed</th>
<th>Noncompleted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989-2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall reoffences</td>
<td>5.7</td>
<td>4.6</td>
<td>4.3</td>
<td>4.9</td>
<td>4.6</td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>1.3</td>
<td>1.2</td>
<td>2.3*</td>
<td>0.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>4.4</td>
<td>3.4</td>
<td>4.6</td>
<td>2.0</td>
<td>3.4</td>
</tr>
<tr>
<td>April, 1993-2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall reoffences</td>
<td>3.8</td>
<td>4.5</td>
<td>1.8</td>
<td>5.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Sexual recidivism</td>
<td>0.8</td>
<td>0.3</td>
<td>0.2</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Nonsexual recidivism</td>
<td>3.0</td>
<td>4.2</td>
<td>1.6</td>
<td>5.6</td>
<td>3.5</td>
</tr>
</tbody>
</table>

* Most offenders committed one reoffence; skewed by multiple reoffences by two of the four completers.

Less harmful reoffending conduct

To determine whether the severity of sexually abusive behaviour by offenders decreased following their contact with Cedar Cottage, the intrusiveness of the index offences was compared to police reports of sexual recidivism offences. This comparison was conducted on the 23 offenders in the study sample who sexually reoffended.

Index offence intrusiveness was determined from information gathered from police interviews and notes recorded by Cedar Cottage staff at the time of the assessment interviews. The most severe reported intrusion was utilised whether reported by victims or offenders. Recidivism intrusiveness was obtained from COPS and coded from the nature of the offence reported or charged. In accordance with the Crimes Act 1900, sexual assault offences were classed as penetrative, indecent assault offences as non-penetrative and grooming/exposure offences as non-contact offences. This approach was not as precise as that used to determine the intrusiveness of index offences but further information about the recidivism offences was not available. The definitions under the Crimes Act 1900 have not changed since March 1991 and the first recidivism offence occurred in 1992. Details regarding the number of victims, ages of youngest victims, and the relationship between the offender and victim are summarised in Table 47.

Seven of the 53 offenders accepted into treatment were reported for sexual reoffending within the study observation period. Of this group, four offenders completed the treatment program, and three breached or withdrew. Of the program completers, in one case (Offender A) both the index offences and relapse offences were penetrative. In two cases (Offenders C and D), sexual offending reduced from penetrative and non-penetrative to non-contact behaviours following treatment. The severity of offending behaviours by two of the three noncompleters was reduced following treatment, but increased for the third noncompleter. One offender who completed the program reoffended against more than one victim.

Sixteen of the offenders who were declined treatment reoffended sexually within the study observation period. Information about the nature of the sexual recidivism was available in 14 of these cases. The reoffending conduct by two offenders in this group was more severe and intrusive than that documented in the index offence; in six cases the degree of intrusiveness was unchanged, and in eight cases, intrusiveness decreased. Six offenders reoffended against more than one victim.
Table 50: Severity of index offences versus sexual reoffences, by group

<table>
<thead>
<tr>
<th>Offender</th>
<th>Penetrative index offence</th>
<th>Age of youngest index victim</th>
<th>No. of index victims</th>
<th>Most intrusive recidivism</th>
<th>Age of youngest victim of recidivism</th>
<th>No. of victims of recidivism</th>
<th>Any related victims of recidivism</th>
<th>Change in severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Y</td>
<td>11</td>
<td>1</td>
<td>Penetrative</td>
<td>11</td>
<td>2</td>
<td>Y</td>
<td>None</td>
</tr>
<tr>
<td>B</td>
<td>N</td>
<td>11</td>
<td>1</td>
<td>Penetrative</td>
<td>14</td>
<td>1</td>
<td>Y</td>
<td>↑</td>
</tr>
<tr>
<td>C</td>
<td>N</td>
<td>11</td>
<td>1</td>
<td>Non-contact</td>
<td>N/A</td>
<td>N/A</td>
<td>N</td>
<td>↓</td>
</tr>
<tr>
<td>D</td>
<td>Y</td>
<td>12</td>
<td>1</td>
<td>Non-contact</td>
<td>51</td>
<td>1</td>
<td>N</td>
<td>↓</td>
</tr>
<tr>
<td>E</td>
<td>N</td>
<td>12</td>
<td>1</td>
<td>Non-contact</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>↓</td>
</tr>
<tr>
<td>F</td>
<td>Y</td>
<td>13</td>
<td>1</td>
<td>Non-contact</td>
<td>N/A</td>
<td>1</td>
<td>Y</td>
<td>↓</td>
</tr>
<tr>
<td>G</td>
<td>N</td>
<td>8</td>
<td>2</td>
<td>Penetrative</td>
<td>8</td>
<td>2</td>
<td>Y</td>
<td>↑</td>
</tr>
<tr>
<td>H</td>
<td>Y</td>
<td>13</td>
<td>1</td>
<td>Penetrative</td>
<td>6</td>
<td>13</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>I</td>
<td>N</td>
<td>9</td>
<td>1</td>
<td>Non-penetrative</td>
<td>16</td>
<td>3</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>J</td>
<td>Y</td>
<td>13</td>
<td>1</td>
<td>Non-penetrative</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>↓</td>
</tr>
<tr>
<td>K</td>
<td>N</td>
<td>10</td>
<td>1</td>
<td>Non-penetrative</td>
<td>12</td>
<td>2</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>L</td>
<td>N</td>
<td>15</td>
<td>1</td>
<td>Non-penetrative</td>
<td>13</td>
<td>1</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>M</td>
<td>Y</td>
<td>8</td>
<td>1</td>
<td>Non-penetrative</td>
<td>N/A</td>
<td>1</td>
<td>N/A</td>
<td>↓</td>
</tr>
<tr>
<td>N</td>
<td>Y</td>
<td>7</td>
<td>1</td>
<td>Penetrative</td>
<td>8</td>
<td>2</td>
<td>Y</td>
<td>None</td>
</tr>
<tr>
<td>O</td>
<td>N</td>
<td>3</td>
<td>1</td>
<td>Penetrative</td>
<td>15</td>
<td>6</td>
<td>N</td>
<td>↑</td>
</tr>
<tr>
<td>P</td>
<td>Y</td>
<td>5</td>
<td>3</td>
<td>Non-contact</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>↓</td>
</tr>
<tr>
<td>Q</td>
<td>Y</td>
<td>3</td>
<td>1</td>
<td>Non-contact</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
<td>↓</td>
</tr>
<tr>
<td>R</td>
<td>Y</td>
<td>8</td>
<td>1</td>
<td>Non-penetrative</td>
<td>8</td>
<td>1</td>
<td>Y</td>
<td>↓</td>
</tr>
<tr>
<td>S</td>
<td>N</td>
<td>1</td>
<td>1</td>
<td>Penetrative</td>
<td>N/A</td>
<td>1</td>
<td>N</td>
<td>↑</td>
</tr>
<tr>
<td>T</td>
<td>Y</td>
<td>9</td>
<td>1</td>
<td>Penetrative</td>
<td>11</td>
<td>2</td>
<td>Y</td>
<td>None</td>
</tr>
<tr>
<td>U</td>
<td>Y</td>
<td>5</td>
<td>2</td>
<td>Non-penetrative</td>
<td>17</td>
<td>1</td>
<td>Y</td>
<td>↓</td>
</tr>
<tr>
<td>V</td>
<td>Y</td>
<td>9</td>
<td>1</td>
<td>Non-contact</td>
<td>N/A</td>
<td>N/A</td>
<td>N</td>
<td>↓</td>
</tr>
<tr>
<td>W</td>
<td>N</td>
<td>5</td>
<td>1</td>
<td>Non-contact</td>
<td>11</td>
<td>1</td>
<td>N</td>
<td>↓</td>
</tr>
</tbody>
</table>

N/A: information not available

A total of four offenders who completed the treatment program at Cedar Cottage in the period 1989 - 2003 were observed to have reoffended sexually. Details descriptive of the four reoffenders’ conduct were extracted from the official police reports to assess the scope of harm inflicted on their victims:

Offender A sexually abused the index victim’s sister for a period of two months within three months of completing the treatment program. He was charged and convicted of three counts of aggravated indecent assault and nine counts of aggravated sexual assault for which he served an eight-year prison sentence. Approximately two years after his release from custody, the NSW Police received a report that he had indecently assaulted his biological daughter (an infant at the time of his treatment at Cedar Cottage). The report was passed on to the Department of Community Services. Although the NSW Police did not doubt the veracity of the report, no criminal investigation ensued.

Offender B reoffended against the index victim, his biological daughter for a period of 3 – 4 months within three months after completing the treatment program. He was charged and convicted of eight
counts of aggravated indecent assault and four counts of aggravated sexual assault, and was incarcerated for six years.

Offender C suffers from Paranoid Schizophrenia, which was diagnosed prior to his treatment at Cedar Cottage. Eight years after completing the program, soon after he learned of the death of his index victim, he was observed walking naked in his front yard. He was charged with wilful and obscene exposure, no conviction ensued.

Seven months after completing the treatment program, Offender D was suspected of peeping and prying on a woman who provided him with some private tuition. She reported to police that she woke up several different occasions and saw a man who resembled Offender D looking through her bedroom window. The victim did not proceed with charges on grounds that she was uncertain of his identity. Distinctive features to identify him were included in her description, so other factors may have contributed to her decision not to press charges.

Clearly, the nature of the sexual reoffences committed by Offenders C and D who attended the program in later years is less severe and less harmful than that of Offenders A and B, two recidivists who attended the program in the earlier years of its operation, as neither of these offenders engaged in a sexual offence with a minor. Offenders A, B and C were referred to the program before April, 1993; Offender D was referred after that date. This analysis of the reoffending behaviours by tends to indicate that the treatment has more effectively minimized harm to victims and the community by offenders referred to the program in the study period after April, 1993.

Prior offending

Prior offending is an important indicator of recidivism. Results reported in Chapter Six demonstrated that there were no significant differences in offender groups with respect to prior offence records. That is, accepted offenders and program completers were no more likely to have a history of criminal offending than declined offenders and noncompleters. Therefore, in the following analyses, the influence of prior offences on estimated lifetime rates of recidivism, time to recidivate and likelihood of reoffending was examined without differentiating offender groups. Prior offending histories were examined in three categories: (a) offenders with no record of prior offences, (b) offenders with a record of prior offences committed as an adult; and (c) offenders with a prior record of offences committed as a juvenile and as an adult.

Table 51: Estimated reoffence rates (percent, number) and mean time to recidivate (years), by offence type and prior criminal history of offenders

<table>
<thead>
<tr>
<th></th>
<th>Overall recidivism</th>
<th>Sexual recidivism</th>
<th>Nonsexual recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total N*</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>No prior offence</td>
<td>96</td>
<td>19</td>
<td>19.8</td>
</tr>
<tr>
<td>Prior adult offences</td>
<td>78</td>
<td>25</td>
<td>32.1</td>
</tr>
<tr>
<td>Prior juvenile and adult offence</td>
<td>39</td>
<td>22</td>
<td>56.4</td>
</tr>
</tbody>
</table>

* One offender with a prior juvenile offence and no prior adult offence was excluded from this analysis

Cox proportional hazards regressions were conducted to investigate the influence of prior offending on overall, sexual and nonsexual reoffending (see Table 48). These analyses revealed that prior offending
significantly predicted the likelihood of overall ($\chi^2 = 16.75$, df= 2, N= 213) and nonsexual ($\chi^2 = 17.04$, df= 2, N= 213) reoffending. Offenders with a prior adult offence were twice as likely to recidivate, and offenders with a juvenile and adult offence history were 3.5 times more likely to recidivate than were offenders with no prior offences. Offenders with a prior adult offence were 2.7 times more likely to recidivate nonsexually, and offenders with prior juvenile and adult offences were 3.6 times more likely to recidivate overall than offenders with no prior offences (see Figures 17 and 18). However, prior offences did not significantly predict the likelihood of sexual reoffending. Although offenders with a prior adult and juvenile offence were more likely to reoffend sexually (20.5%) than offenders with no prior offences, this difference was not statistically significant.

**Figure 17. Overall recidivism survival 1989-2007, by offending history**

![Graph showing overall recidivism survival](image-url)

**Figure 18. Nonsexual recidivism survival 1989-2007, by offending history**

![Graph showing nonsexual recidivism survival](image-url)
STATIC-99 scores and recidivism

To examine the relationship between offenders’ scores on the STATIC-99 and reoffence rates, offenders were divided into two groups based on the distribution of their STATIC-99 scores: those who scored zero versus those whose scores exceeded zero (range= 1-7). Offenders who scored zero had a similar sexual reoffence rate to offenders who scored 1-7 on the STATIC-99 (see Table 45). Overall and nonsexual recidivism rates among offenders who scored zero on the STATIC-99 were lower than those among offenders with higher STATIC-99 scores, but, these differences were nonsignificant. Bonferroni adjusted t-tests, with an alpha level of 0.016, revealed that STATIC-99 scores were not significantly related to time to reoffend overall, sexually or non-sexually.

Table 52: Reoffence rates (percent, number) and time to recidivate (years), by STATIC-99 scores

<table>
<thead>
<tr>
<th>STATIC-99 score</th>
<th>Overall recidivism</th>
<th>Sexual recidivism</th>
<th>Nonsexual recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total N*</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>145</td>
<td>39</td>
<td>26.9</td>
</tr>
<tr>
<td>1-7</td>
<td>68</td>
<td>27</td>
<td>39.7</td>
</tr>
</tbody>
</table>

* No score was calculated for one offender who passed away

Cox proportional hazards regression analyses were conducted to investigate whether STATIC-99 scores predicted offenders’ likelihood of reoffending. These analyses revealed that STATIC-99 scores significantly predicted the likelihood of overall ($\chi^2= 4.46$, df= 1, N= 213) and nonsexual ($\chi^2= 4.63$, df= 1, N= 213) reoffending. Offenders with a STATIC-99 of 1-7 were 1.7 times more likely to recidivate overall and 1.8 times more likely to recidivate nonsexually, than offenders with a STATIC-99 score of zero. STATIC-99 scores did not significantly predict the likelihood of sexual reoffending.

Acceptance of responsibility and recidivism

To examine whether acceptance of responsibility for offending behaviour was instrumental in reducing relapses, offenders’ accounts of their abuse delivered at the point of last contact with Cedar Cottage were recoded categorically, as either accepting full responsibility or not. The degree to which offenders accepted responsibility for their abusive conduct did not differ between offenders treated during the two referral periods, before and after April 1993.

In general, observed recidivism rates were higher among offenders who did not accept full responsibility for their abusive behaviour at the point of their last contact with Cedar Cottage. Offenders who had not accepted full responsibility for their abusive behaviour at the point of their last contact with Cedar Cottage were more likely to reoffend. This trend is demonstrated with respect to overall, sexual and nonsexual recidivism, as is shown in Table 46; however the difference was statistically significant only for overall recidivism rates ($\chi^2= 4.81$, df= 1, N= 214). Offenders who did not accept responsibility for their offending behaviour had rates of overall recidivism almost twice as high as those of offenders who accepted responsibility. Logistic regression analyses revealed that the sexual and nonsexual recidivism rates did not differ significantly between offenders who accepted full responsibility for their offending behaviour and those who did not. Bonferroni adjusted independent sample t-tests, with alpha level of 0.016, produced no significant difference between time to recidivate sexually and nonsexually by acceptance of responsibility.
Table 53: Acceptance of responsibility and recidivism rates (number, percent, and time to recidivate)

<table>
<thead>
<tr>
<th></th>
<th>Overall recidivism</th>
<th>Sexual recidivism</th>
<th>Nonsexual recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total N</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Accepts responsibility</td>
<td>68*</td>
<td>14</td>
<td>20.6</td>
</tr>
<tr>
<td>Does not accept respons</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Excludes 4 offenders for whom no data on acceptance of responsibility were recorded.

Note: Years = time following last contact with Cedar Cottage before first reoffence.

Analysis of the number of offences committed by reoffenders showed that a range between 1 and 16 reoffences. Offenders who accepted responsibility for their offending behaviour committed fewer overall reoffences (4) and sexual reoffences (1) than offenders who did not accept responsibility (6 and 8 reoffences, respectively). Bonferroni-adjusted independent samples t-tests with alpha levels set at 0.016 revealed these differences to be nonsignificant. The average number of nonsexual reoffences did not differ by acceptance of responsibility (an average of four reoffences in each responsibility group).

Cox proportional hazard regression analyses were conducted to investigate the influence of acceptance of responsibility on the likelihood of reoffending. Acceptance of responsibility significantly predicted likelihood of overall reoffending ($\chi^2 = 5.10$, df= 1, N= 93); offenders who accepted responsibility for their abusive behaviour were 64% less likely to reoffend overall, than offenders who did not accept responsibility (see Figure 19). However, acceptance of responsibility did not significantly predict the likelihood of sexual or nonsexual reoffending.

Figure 19. Overall recidivism by acceptance of responsibility for offending

Summary

The reduction in recidivism observed in the group accepted for treatment at Cedar Cottage conformed with effect sizes in meta-analyses of sexual offender treatment programs (Lösel & Schmucker, 2005). The totality of the multiple measures of harm reduction converged to cross-validate the overall finding that the treatment program was a successful intervention, with considerable practical significance.
CHAPTER 8
CONCLUSIONS

Significance of the empirical findings ................................................................. 106
Common misperceptions about intrafamilial child sex offenders ....................... 107
Effectiveness of the program in reducing relapses and reoffence rates ................ 109
The role of acceptance of responsibility in reducing recidivism .......................... 111
Cost-effectiveness of the diversion program ....................................................... 112
Effective harm reduction and benefits to victims and their families ................... 113
Underutilisation of the program: barriers to referrals of eligible offenders ............ 113
Diversion as a model of therapeutic jurisprudence and restorative justice .......... 114
Summary ........................................................................................................... 114
CHAPTER 8

CONCLUSIONS

The incidence of intrafamilial sexual offending in the community is a serious social problem. Recent statistics indicate that both the number of offenders charged and the number convicted annually in New South Wales are increasing. Accordingly, documentation of the success of an intervention program in reducing the rates of reoffending, diminishing the harm to victims, and expanding benefits to victims and their families is of considerable significance. The remarkably successful outcomes of this Diversion Program must be viewed in the context of other comparatively costly prison-based and community-based offender treatment programs, most of which are unable to demonstrate any effects of treatment.

Significance of the empirical findings

The sample of 214 offenders referred to the NSW Pre-Trial Diversion Program for Offenders (Child Sexual Assault) included in this evaluation project comprises one of the few community-based adult sex offender samples empirically studied, and one of the largest known cohorts of intrafamilial sex offenders to date. By including official police reports as well as conviction rates as measures to discern reoffending, the study not only demonstrated that official convictions missed 40% of the recidivism recorded in official police reports, but yielded a more fine-grained picture of the offending behaviours of the study sample following their contact with Cedar Cottage, irrespective of whether they experienced a traditional criminal sentencing procedure or were diverted to the community-based sanctions. A follow-up period of 4 to 18 years is far more extensive than that included in most other recidivism studies, allowing insights into relapses in both the short-term as well as the long-term. Detailed analyses of the index offences demonstrated that the screening process during the Cedar Cottage assessment period did not differentiate the treatment from the control group, or deselect higher risk offenders who committed more egregious sexual offences. By including all offenders referred to Cedar Cottage in the study sample, this evaluation achieved at least Level Three on the Maryland Scale of Scientific Rigour, securing its place among the minority of studies that have sufficient methodological controls over treated versus untreated groups to draw meaningful inferences about the impact of the program on sexual reoffending rates. For the foregoing reasons, the findings in this report make a unique and substantial contribution both to the Australian and international literature on a sub-group of adult sex-offenders about whom little is known, and to the literature on outcomes of community-based interventions to reduce sexual reoffending.

The comprehensive data extracted from treatment files and compiled in the course of this evaluation generated an in-depth profile of the group of intrafamilial offenders referred to the NSW Pre-Trial Diversion Program over a period spanning 18 years. These evaluation outcomes are helpful in demystifying aspects of intrafamilial sex offending and in developing a more comprehensive portrait of the types of abusive conduct in issue, the duration of the offences, and the consequences for victims. The findings provide valuable practical guidance for crime prevention and law enforcement, for future planning and policy development regarding community-based and institutional treatment programs, and sentencing.
Common misperceptions about intrafamilial child sex offenders

This evaluation yielded fresh insights into the demographic features and characteristics of intrafamilial sex offenders and a detailed description of the nature and scope of index offences committed. These data controverted a series of common beliefs and conceptions about intrafamilial child sex offenders. As a result, a number of myths and misconceptions about incest were identified. In all, seven erroneous beliefs controverted by findings in this study were noted:

First, one common perception of intrafamilial sex offenders and of the referrals to Cedar Cottage is that they are “one-off” offenders, who engage in sexually abusive behaviour on a single occasion only. Results of this evaluation demonstrated that this perception was largely inaccurate, first and foremost because the duration of most index offences exceeded three years and entailed multiple incidents of abuse. More than half of the index offences included between 2 and 50 separate incidents of abuse. In fact, the index offences of only three offenders (1%) involved commission of one abusive act on a single occasion, and a further 20 offenders committed an average of 2 or 3 abusive acts in the course of a single index offence. In sum, the description of intrafamilial offenders as “one-off” offenders was accurate for only 10% of the referrals. A further noteworthy point is that most offenders accepted into the program following a single incident of abuse had committed a penetrative abusive act (91%, n= 21). For the majority of offenders, the index offence was not the most extensive abusive behaviour by the offender, demonstrating that intrafamilial offenders are more deviant and less circumstantially or contextually motivated than has often been presumed. One in 10 referrals had a history of sexual offending that had come to the attention of the police; 1 in 20 had a prior conviction for a sexual offence (notwithstanding the fact that this should have precluded their referral to Cedar Cottage).

Second, another widespread misperception of intrafamilial sex offenders is that the nature of their abusive behaviours is less severe or egregious than is typical in the case of sexual assault by a stranger, i.e., that it is mostly limited to milder forms of sexual behaviour, such as non-contact grooming, exposure or hands-on contact such as fondling. In fact, only one offender was referred for a non-contact offence. The evaluation revealed that a clear majority of the referrals (86%) committed a penetrative sexual offence, and that penetrative abuse was more common than sexual touching or no-contact offences, irrespective of the age of the victim. A wide range of abusive acts were committed by the offenders, including vaginal penetration of 77% of female victims. Moreover, approximately 1 in 4 victims experienced sexual abuse accompanied by extortion, threats of violence or physical violence. These findings indicated that the sexually deviant practices exhibited by this group of intrafamilial child sex offenders were similar to those of extrafamilial child sex offenders.

A third mistaken belief about the perpetrators of intrafamilial child sexual abuse is that they are typically parental figures who have no blood relation to the victims, such as step-fathers or foster-fathers. The referral group included a fairly even representation of nonbiological fathers (55%) and biological fathers (45%), allowing a thorough investigation of this issue. On almost all measures, these groups were undifferentiated. Although biological fathers were significantly older at time of the first incident of abuse and at the time of referral than were nonbiological fathers, the practical difference in the mean age of the two groups was small, i.e., 3 years. Biological fathers tended to offend against significantly younger victims, probably because they had greater access to younger victims than did stepfathers, who may have joined the family unit only after the biological father and mother separated, by which time the children were older. The stereotype was thoroughly repudiated by the finding that two-thirds of the victims of sexual reoffences identified biological rather than nonbiological fathers as...
the perpetrators. No significant differences between biological and nonbiological fathers emerged in rates of recidivism or time to recidivate. Biological and nonbiological fathers demonstrated similar levels of acceptance of responsibility for their conduct. Overall, few meaningful differences between these groups emerged in this study.

A fourth stereotype of incest offenders is that their transgressions are typically with postpubescent or sexually mature teenagers, with the implication that the offender was contextually or circumstantially provoked. A small minority of the offenders in this sample, only 7%, were referred for abusing children over the age of 14 years. A review of the details of the index offences confirmed that more than 90% of the victims were female children; however, two-thirds of all the victims were under the age of ten years. The average age of child victims at the time of the first reported incident of abuse was 8 years. These data thoroughly refuted that stereotype.

Fifth, another pervasive misconception of intrafamilial sex offenders is that they are otherwise law-abiding and have lapsed only in regard to their sexual impulses. The error of this view was highlighted by the finding that most of the referrals to Cedar Cottage had some prior history of criminal offending. More than half of the referrals (55%) had a record of past criminal conduct, and 45% had prior convictions. The majority of the past offences were for nonsexual, non-violent criminal conduct (42%). More of the referrals had a prior conviction for a violent offence than for a sexual offence (15% vs. 10%). Approximately 20% of the offenders started offending during adolescence and continued into adulthood; just over one third (36%) offended only during adulthood. The majority of offenders who had reports or convictions for prior offences had committed these offences during adulthood. The recidivism data confirmed that 31% of this cohort reoffended nonsexually.

Sixth, many people, including some researchers, perceive intrafamilial sex offenders to be just like other child sex offenders but for the parental relationship with their victims. However, the demographic characteristics of the majority of referrals included in this study sample did not resemble those of many other sex offenders with respect to three key variables: marital status, employment status and age. First, unlike many other sex offenders, the offenders in this sample were involved in long-term intimate relationships with a significant other, usually the nonoffending parent. Most of the referred offenders were legally married or in a common law marriage (85%). Whereas a long-term intimate relationship with an adult is regarded as a protective factor that minimizes the risk of offending in extrafamilial sex offenders, this relationship does not reduce risk in intrafamilial sex offenders. Second, in general, their employment histories revealed a pattern of ongoing, steady work. Only 10% of the sample was identified as having difficulty in maintaining steady employment. Third, the age range of these offenders at the time of referral, 39 years on average, exceeded that of many other offenders. In fact, with respect to their marital status, employment status and age, this cohort of intrafamilial sex offenders appears almost indistinguishable from many stable members of the community.

Finally, a common stereotype regarding child sex offenders is that they are perpetuating a cycle of abuse that they themselves experienced as children. This demographic variable is less readily apparent than marital status, employment status or age. Our examination of evidence of a history of childhood abuse in the offender sample revealed that a sizeable proportion of the referrals, more than one-third, self-reported that they themselves were victims of childhood sexual abuse (38%). Psychological and/or physical abuse was experienced by 23% of the sample. In all, close to half of the referrals, 46% reported that they were childhood victims of one or more forms of abusive behaviour. These findings are consistent with outcomes of studies of prior sexual abuse in adolescent sex offenders, where rate of 4
out of 10 has been reported (Worling, 1995). Interestingly, the proportion of offenders who engaged in substance abuse was comparable, i.e., 45% had a history of drug or alcohol abuse. While these findings tend to confirm that cycles of abuse were perpetuated by a substantial proportion of the offenders referred to Cedar Cottage, for at least the balance of the group, 54% of the offenders, there was no evidence of childhood abuse. In other words, this demographic history was just as likely to be absent as to be present. Thus, the findings from this sample of intrafamilial child sex offenders substantially limited the generality or accuracy of this stereotype.

In sum, this study produced unique and informative data that are instrumental in addressing a number of stereotypes about intrafamilial sex offenders. These findings serve a social benefit by expanding our knowledge and understanding of the nature and scope of intrafamilial sex offending and by demystifying many dimensions of this social problem. This information will be of value not only to the Cedar Cottage Program Director and staff, but to other clinical and legal practitioners, future researchers and policy-makers in planning and delivering treatment, in devising appropriate sentences for intrafamilial child sex offenders.

**Effectiveness of the program in reducing relapses and reoffence rates**

The extensive review by the Campbell Collaboration on the influence of custodial versus noncustodial sentences on reoffending in the United Kingdom (Villettaz, Killias, & Zoder, 2006) determined that non-custodial sanctions did not result in lower rates of reoffending beyond random effects. The major question addressed in this evaluation was whether the community-based New South Wales Pre-Trial Diversion Program reduced the recidivism rate of the offenders accepted for treatment and among program completers and noncompleters.

Overall, the results showed that the Cedar Cottage treatment program produced a sharp drop in the estimated lifetime reoffending rate for sexual offences, from 13.9% (17 out of 122 offenders) to 7.5% (7 out of 93 offenders). These numbers were derived by applying survival analysis, which takes actual reoffence data from persons who have been at risk of offending from anywhere between 4 and 18 years, and extrapolates this to a lifetime risk of reoffending at least once. In making these estimates we included all offenders who breached or who chose to leave the program, which equated to almost half of the number accepted for treatment. This conservative procedure may understate some of the effects of the treatment program.

Examination of the program outcomes in more detail showed that the first four years of the program (1989-1993) did not seem to have any marked effect on offenders’ reconviction levels. The estimated lifetime reoffending rates for sexual offences was almost the same for those who entered the program (13.8%) as for those who did not (14.9%). In the period after the legislative amendments came into effect, from 1993 to 2003, the program did seem to have a major impact: offenders who did not enter the program in that period had an estimated lifetime reoffending rate for sexual offences of 12% whereas the rate among those who participated in the program dropped dramatically to under 5%--even if they did not complete treatment. Given that the equivalent rate for the 1989-1992 cohorts was 14%, a recidivism rate of less than 5% is a success by any measure.

Nonsexual offending also declined following acceptance into the Cedar Cottage treatment program, but not to the same extent. A smaller, but still impressive decline for nonsexual recidivism was observed from 1993-2007: a drop from 31% before 1993 to 23% after 1993.
Where no randomized controls are possible, the Campbell Collaboration recommends comparisons of relative improvements in recidivism rates of the accepted versus declined groups, rather than comparisons of absolute levels of reoffending. With respect to sexual recidivism, in the period 1993 – 2007, participation in the Cedar Cottage program reduced reoffending by more than three-fifths (61.5%). In other words, the rate of sexual reoffending among offenders accepted into the treatment program was reduced from 1 in 9 to 1 in 20 following their contact with Cedar Cottage. Treatment completion reduced the overall estimated lifetime reoffence rate by more than a half (56.7%) and the estimated lifetime reoffence rate for nonsexual recidivism by three-fifths (60.7%).

In the period 1993-2007, the relative reduction in overall recidivism was 30.8% and in nonsexual recidivism 34.7% among offenders accepted into the program. Put another way, after 1993, 1 in 3 offenders who were declined treatment reoffended overall and nonsexually, but in those offenders accepted into the program, this rate was reduced to 1 in 5.

As one might expect, in the total sample, a history of prior criminal offences significantly predicted overall and nonsexual estimated lifetime recidivism but not sexual recidivism. Offenders with an adult prior offence were 2.7 times more likely to recidivate overall. This proclivity was higher in offenders with both a juvenile and an adult prior offence, who were 3.6 times more likely to recidivate overall than offenders with no history of prior offending. Offenders who were older at the time of referral to Cedar Cottage were significantly less likely to reoffend than their younger counterparts, irrespective of a past criminal record.

While a number of tests comparing the accepted and declined groups did not yield statistically significant differences, the lack of statistical significance was anticipated because of low statistical power to detect the effects of treatment given the small number of reoffenders and the low base rates of sexual reoffending. However, the group means consistently demonstrated dramatic reductions in recidivism by offenders in the accepted compared to the declined group. Confirmation of the effectiveness of the Cedar Cottage intervention was evident in the fact that the magnitude of the observed reduction in recidivism in the group accepted for treatment matched the effect size in recidivism rates typically observed in meta-analyses of other treated sexual offenders (Lösel, 1996; Howells & Day, 1999; Losel & Schmucker, 2005). The overall pattern of the results, documented across many measures, was consistent, providing important cross-validation of these outcomes. The totality of these comprehensive findings converged to support the conclusion that the treatment program was a successful intervention, with considerable practical significance.

The Campbell reviewers concluded that frequently observed nonsignificant results in studies of this type are “likely due to insufficient control of pre-intervention differences between prisoners and those serving ‘alternative’ sanctions,” (Villettaz, Killias, & Zoder, 2006, p.1). In this study, because no randomized control of the allocation of offenders to one group versus the other was feasible, extensive comparisons were made of similarities and differences between offenders that accepted and declined treatment. These analyses revealed more demographic similarities than differences between these groups, indicating that the reduction in recidivism observed in the accepted groups was not attributable to demographic differences between offenders in the accepted and declined groups. It is also possible that recidivism rates were influenced by differences between the accepted and the declined groups that were not measured in this study, e.g., dynamic factors such as their willingness to accept treatment, genuineness of contrition, or likelihood of benefiting from therapy. Given the retrospective nature of this evaluation, analysis of many dynamic variables was infeasible and not the major focus. However,
one dynamic factor was investigated: acceptance of responsibility by offenders for their abusive conduct.

The role of acceptance of responsibility in reducing recidivism

Previous researchers have pointed out that treatment effectiveness studies should not focus exclusively on outcomes such as a reduction in recidivism rates, but should identify and examine factors that change through treatment, in particular dynamic risk factors, such as deviant attitudes held by offenders (Collins, Peters & Lennings, 2009). Acceptance of responsibility for offending behaviours indicates a reduction in deviant attitudes and cognitions, and is a dynamic risk factor central to the Cedar Cottage treatment program. Few studies have demonstrated a relationship between reoffence rates and acceptance of responsibility. This evaluation produced important insights into the extent to which the acknowledgement of responsibility for sexual abuse influenced reoffending behaviours. Offenders who had accepted responsibility for their abusive behaviour at the point of their last contact with Cedar Cottage were less likely to reoffend than their counterparts who did not accept responsibility for their offending behaviour. The most dramatic reduction in reoffending associated with acceptance of responsibility was for sexual reoffending (5.9% vs. 13.6%), although differences for nonsexual reoffending (17.6% vs. 31.8%) and overall reoffending (20.6% vs. 40.9%) were also substantial. Acceptance of responsibility significantly reduced the likelihood of reoffending. In addition, offenders who did not accept full responsibility for their abusive conduct at the point of their last contact with Cedar Cottage went on to commit a significantly higher number of sexual reoffences than offenders who accepted responsibility. These findings provided important evidence of the role that a change in the acceptance of responsibility can play in reducing further criminal conduct.

A key component of the Cedar Cottage treatment program that promotes acceptance of responsibility for offending behaviours is the emphasis on “face-ups” that offenders prepare for presentation to the victim, the non-offending parent or a significant friend or family member. The evaluation included an analysis of the extent to which offenders who were admitted into the treatment program faced up to their victims and families, and the nature and scope of any differences between treatment completers and noncompleters in this regard. Results revealed that all program completers prepared and delivered face-ups to a nonoffending parent or victim, whereas only 57.5% of the noncompleters did so. A content analysis of the face-ups provided an indication of the extent to which offenders took responsibility for their abusive behaviour and the extent to which the victims’ accounts were validated by the offender. The content of face-up statements prepared by treatment completers were significantly more likely to match the scope of the victims’ disclosure than were statements prepared by noncompleters. Offenders who completed the treatment program were twice as likely as noncompleters to accept responsibility for their abusive conduct.

A related question investigated in this evaluation was the nature of any differences in the admissions and disclosures made by treatment completers versus noncompleters regarding their offending behaviour. Offenders’ final accounts of their offences were compared with victim accounts provided to police. The accounts by offenders who completed treatment contained significantly more details and supplementary information beyond that provided by the victim than the counts by noncompleters. For example, offenders disclosed commencing abusive conduct when the victim was younger in age than the victim herself recalled, that the offending continued for periods longer than those described by the victims, that a wider range of abusive acts in a wider range of locations were committed that were itemized by the victims, and that they committed more intrusive acts than were reported by the victims.
These disclosures indicated that the offenders accepted responsibility not only for the offences nominated in the criminal charges brought by the Director of Public Prosecutions, but more generally, for the full range of their abusive conduct.

Most typically, the incentives in traditional sentencing procedures are such that offenders persist in denial of their offending, even after a sentence has been imposed. An unanticipated attribute of the treatment program was the finding of expanded disclosure by offenders of the scope of their offending conduct, including the disclosure of a number of unknown victims in the course of treatment. This outcome demonstrated acceptance of responsibility by the offenders to an unusual degree in a sentencing context. These expanded disclosures conferred an important benefit on victims whose experiences of abuse had not been disclosed before the offender entered treatment: the previously unknown victim's experience was validated, and the victim was provided an opportunity to seek justice and treatment.

**Cost-effectiveness of the diversion program**

Another important dimension in which benefits and cost savings of the community-based intervention program can be assessed is by comparing the terms of the average cost of the prosecution and incarceration of sex offenders in New South Wales today with the cost of treatment provided at Cedar Cottage.

Although an extensive analysis and in-depth cost assessment (e.g., along the lines of cost-effectiveness assessments commissioned by community-based programs in New Zealand; Lambie, 2007) was beyond the scope of this evaluation, some brief observations about the relative costs and benefits of prison-based versus community-based programs are relevant.

In 1992, the direct cost of treatment and other services to 18 offenders accepted at Cedar Cottage was estimated to be equivalent to the cost of incarcerating 18 offenders, based on typical sentencing patterns ($340,000 vs. $332,407, respectively). Notably, the cost for each offender accepted by Cedar Cottage was inclusive of costs of treatment and other services provided to victims, non-offending parents, and other non-offender clients—on average six individuals in addition to each offender who was served by the Cedar Cottage program. By contrast, the cost for each incarcerated offender did not include treatment costs for the offender, nor for any victims or other family members. At the time that these cost comparison were made, Cedar Cottage was underutilized and was not operating at full capacity. The evaluator noted that estimated treatment costs per offender in the community-based program under optimal capacity conditions would be lower (Vinson, 1992).

These costs of incarceration have increased substantially since 1992. Between 1995/96 and 2005/06, the NSW State Budget for prison expenses more than doubled, from $355m to $763m (BBA, nd). Costs of incarceration can be subdivided into direct and indirect costs. The former include all standard out-of-pocket expenditures, excluding the costs of treatment in prison. Direct costs are usually reported as the daily cost per prisoner/offender. The direct cost of incarceration is generally between 15 and 25 times higher than community-based treatment ($145-245 vs. $10-13 per day for 2000-2006) (BBA, nd; SCRGSP, 2002; SCRGSP, 2008). Indirect costs include the consequences faced by inmates and offenders after conviction. Imprisonment often leads to loss of housing, unemployment and poorer health due to increased drug use, suicide or mental health problems caused by traumata (BBA, nd). Thus, the total fiscal savings accomplished through implementation of a community-based treatment program such as Cedar Cottage, even in the absence of any reduction in reoffending rates, are considerable. When the
The reduction in costs to taxpayers that follow when a community-based program successfully reduces offending behaviour are considerable.

**Effective harm reduction and benefits to victims and their families**

A number of important findings emerged from the evaluation with respect to the Cedar Cottage program goals of harm minimization. These findings have implications for the wellbeing and safety of individual victims, their families and the wider community.

First, taking into account the estimate of six family members associated with each offender in treatment at Cedar Cottage, the total number of clients who benefited directly from the treatment program in the study period is approximately 725. However, the benefits should also be computed in terms of the reduction in the number of offenders in the community and the rate of crime in the community, as the treatment program will spare these children and others the trauma of possible sexual abuse in the future.

Reports of the rates of child sexual abuse in New South Wale show that approximately 1000 children are victimized annually, most by persons known to the child in a care-giving role. Approximately 10000 victims of child sexual abuse were identified in formal legal procedures in the 10-year period 1993-2003. Taking into account the expected sexual recidivism rate in the group without treatment of 12%, and the reduction in recidivism following treatment, an estimate can be made of the number of victims whose lives would be spared the trauma of sexual violation by a family member as a result of this treatment intervention program. In a ten year period, approximately 1200 children would be spared the trauma of sexual violation by a family member if this program continues to operate at its current level. The level of harm reduction can be substantially increased if the referral rate is increased so that the program operates at full capacity.

**Underutilisation of the program: barriers to referrals of eligible offenders**

The size of the study sample was limited by the low referral rate of eligible offenders to Cedar Cottage. From the time the program was established in 1989, it has operated under capacity. Although the program has the capacity to accommodate 25 offenders in treatment at one time, rates of referral have never approached these limits. To date, no eligible offenders accepted into the program have been denied treatment. The low rate of referral is not attributable to any dearth of eligible offenders. Current reports of charges for child sexual offences in New South Wales show little variation since 2004—an average of 550 individuals are charged per year. Although the available statistics do not distinguish between intrafamilial and extrafamilial offenders, those data make it clear that referrals to Cedar Cottage comprise only 1.3% of the group of offenders charged with child sexual offences in New South Wales in the period 2004-2006.

Fluctuations in referrals to Cedar Cottage are unrelated to offence rates. The number of annual referrals is dependent upon effective dissemination of information about the availability of the treatment program within the community, specifically by the NSW Police, the Office of the Director of Public Prosecutions and Local and District Courts. Thus, the barrier to appears to be a lack of information about the program or misinformation about the program criteria by the NSW Police, the Office of the Director of Public Prosecutions and Local and District Courts. Misunderstandings by members of the criminal defence bar regarding the timing of the requirement to plead guilty, namely that this plea is
entered following and not prior to the eight-week assessment period, may contribute to underutilisation of the Cedar Cottage Pre-Trial Diversion Program.

The significance of the underutilization of the program is particularly relevant in light of the current interest in community-based alternatives to traditional sentencing.

**Diversion as a model of therapeutic jurisprudence and restorative justice**

The significance of these evaluation outcomes is particularly relevant in light of the current interest in community-based alternatives to traditional sentencing, and in diversionary sentencing programs that include a treatment component, to implement the goals of therapeutic jurisprudence and restorative justice (Winick, 2000).

Therapeutic jurisprudence is a mental health approach to the legal system, taking into account the emotional well-being of those affected by the crime (Wexler & Winick, 2003), including the offender, the victim and other members of the community. The philosophy of restorative justice integrates sentencing and treatment programs that seek to repair the harm done to the community (Douglas, 2007). This approach to sentencing draws on fundamental social values including the importance of relationships, trust and procedural fairness (Freiberg, 2002) and the expertise of multiple professionals (legal professionals, social workers, psychologists, etc.; Sherman, Strang, & Woods, 2003) to offer a more comprehensive and holistic approach to the law and offender rehabilitation. The Cedar Cottage program integrates and exemplifies these attributes.

With respect to the victims of child sexual assault, numerous initiatives introduced to address the attrition of complaints and acknowledged problems faced by child complainants in court have achieved only limited success (Richards, 2009). A noteworthy tangible benefit to victims associated with the Cedar Cottage diversion program is alleviation of the burden on child complainants of participating in the formal legal process. In addition, the Cedar Cottage program provides sexual assault counselling and forensic services for these victims, in conformity with recommendations for child sexual assault victims by the Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008). Problem-solving and specialty courts are vulnerable to criticism as resource intensive, posing some ethical dilemmas for judges (Bartels, 2009) and not necessarily achieving reduced recidivism (King, Freiberg, Bagatol & Hyams, 2009). The Pre-trial Diversion program at Cedar Cottage operates without judicial oversight or intervention, yet incorporates the therapeutic and restorative elements of those courts, without their disadvantages, and reduces recidivism.

**Summary**

Children have a right to a safe family environment, to bodily integrity and to protection from violence, rights not only asserted by international conventions but endorsed by federal and state governments in Australia. One of the most serious violations of the right to a loving environment is sexual abuse of a child by a person with responsibility for their care, in many cases a father or guardian. The results of this evaluation demonstrated that the Cedar Cottage treatment program effectively strengthened relationships between victims and nonoffending parents and siblings, but minimized ongoing trauma and lifetime suffering for the victims of intrafamilial child sex offending. Notably, this program is fully compatible with contemporary national and local initiatives, such as those implemented by the Council of Australian Governments (2009): it effectively prevents child sexual abuse and exploitation, ensures that survivors receive adequate support, provides therapeutic and support services for families and children at risk of abuse, and strengthens family relationships.
CHAPTER 9
RECOMMENDATIONS

Dissemination of information about the Cedar Cottage Treatment Program ......................... 116
Recommendations regarding procedures to continue treatment ........................................... 117
Recommendations regarding future evaluation and research ............................................. 118
Summary .................................................................................................................................. 119
CHAPTER 9
RECOMMENDATIONS

Recommendations based on the preceding findings address three broad topics: (a) dissemination of information about the availability of the Cedar Cottage treatment program, (b) procedures concerning treatment, and (c) future evaluation and research.

Dissemination of information about the Cedar Cottage Treatment Program

One limitation in drawing conclusions about the evaluation project data is the absence of official data in New South Wales on rates of intrafamilial child sexual offending. Official data are available on charges and the rates of convictions for all child sexual offending in New South Wales, but currently there is no official monitoring of rates of intrafamilial child sexual offending, either in the form of reports, charges, arrests, or convictions. Despite extensive regulations on mandatory reporting of child sexual abuse, and widespread knowledge that intrafamilial offences comprise the majority of these types of offences, the nature of the data collected lack specificity in this regard. As a consequence, no precise estimate could be offered of the proportion of eligible NSW child intrafamilial offenders who are referred to Cedar Cottage for treatment. The absence of these data precludes inferences about the extent to which the sample of offenders treated at Cedar Cottage is representative of intrafamilial sexual offenders in New South Wales.

Recommendation 1: Steps should be taken to ensure the systematic compilation of data on rates intrafamilial sexual offending in New South Wales, perhaps implemented through cooperation between the Department of Community Services, the NSW Police, NSW Health, and the NSW courts.

Fluctuations in the rates of referral of offenders to Cedar Cottage bear no relationship to rates of child sexual offending in New South Wales. Throughout its existence, the Cedar Cottage Program has been underutilised, and has not operated at full capacity. In the period 2004-2006, 1.3% of all persons charged with at least one Child Sexual Offence were referred to the Program. To promote use of Cedar Cottage at its full capacity, steps must be taken to increase the rate of referrals of eligible intrafamilial offenders. The source of the problem appears to a deficit in the effective dissemination of information about the program. Four potential barriers to the referral of eligible offenders were identified. A lack of awareness of the program at any one of these points inhibits the appropriate referral of eligible offenders for treatment. Given the scarcity of places in treatment programs for sex offenders in the community, it is important that information about the readily available pre-trial treatment for intrafamilial offenders at Cedar Cottage is widely disseminated.

Recommendation 2: An appropriately framed awareness campaign should be developed to target the following four sources of potential referrals to Cedar Cottage, to ensure that they are well-informed of the nature of the eligibility requirements for referral, the procedures for assessment, in particular, the timing of a plea of guilt following the assessment determination. (a) NSW police who receive reports of intrafamilial offences; (b) personnel at the office of the Director of Public Prosecutions responsible for pressing charges of intrafamilial child sexual offences; (c) judges in local and district courts who preside over criminal trials of child sexual offenders; and (d) members of the criminal defence bar who represent intrafamilial child sex offenders.
The delay between the onset of offending and referral to Cedar Cottage is lengthy, an average of three years. This must be viewed in light of the finding that most victims were under the age of 10 years and that most victims experience moderate or severe psychological injuries as a consequence of intrafamilial sexual abuse. The later the referral, the longer before victims receive appropriate treatment and assistance.

**Recommendation 3:** Efforts should be made to implement procedures to minimise the delay between reports of offending and referral to Cedar Cottage. Reasons for this urgency should be included in educational program about Cedar Cottage presented to NSW Police, Department of Community Services staff, and other agencies that receive reports of child sexual abuse.

**Recommendations regarding procedures to continue treatment**

Recommendations are made with regard to (a) disclosures of additional offences beyond the index offence; (b) procedures to discourage noncompletion of treatment; and (c) provisions for continuation of supervision and treatment beyond the treatment completion date.

With respect to offending behaviours that occur during treatment, a policy of zero tolerance applies. Current procedures for handling relapses may serve as disincentives for offenders to disclose relevant information during treatment. Offenders who terminate the program early are returned to court for traditional sentencing, which may entail a period of incarceration.

**Recommendation 4:** To maximise the beneficial effects of treatment, procedures to retain individuals in the program following assessment should be implemented. This may require a defined process to review treatment status and recommendations for continuation of treatment. Differentiation may be appropriate between consequences for individuals who (a) breach the treatment agreement; (b) voluntarily withdraw from treatment; (c) have minor lapses during treatment; and (d) have more serious relapses during treatment.

In the course of treatment, offenders disclosed additional victims and additional occasions of abuse beyond the information contained in the charges associated with the index offence. Currently, a disclosure of a new offence or additional victims during treatment triggers mandatory reporting requirements. Cedar Cottage staff ensure these reports are transmitted to the police, either by the offender who has disclosed the new information, or a staff member. These disclosures can result in new charges against and additional sentencing of the offender. These penalties are disincentives to disclosure. Nondisclosure impedes effective intervention and remedial treatment, and denies justice to the victims.

**Recommendation 5:** In instances where the law does not require imprisonment for the disclosed offending behaviours, disclosure of additional offences prior to the index offence or of additional victims over and above the index victim should be encouraged so that more victims can be validated and the true extent of intrafamilial sexual offending can be determined.

The dropout rate observed in the study period was 43%. Limiting dropouts, whether by breach or voluntary withdrawal is desirable. With regard to noncompletion by breach, procedures are in place for the Director to report these instances and the circumstances surrounding the breach to the court. However, when an offender voluntarily withdraws from the treatment program, no similar procedure exists for the Director to inform the court of the reasons and circumstances surrounding these instances of noncompletion.
Recommendation 6: Following notification of a withdrawal, the court should order a process of family review to be provided by Cedar Cottage to document the circumstances of withdrawal.

At present, the treatment program offers offenders a minimum of two and a maximum of three years of treatment. No provision for post-treatment supervision is included, analogous to that available through the Department of Corrections Probation and Parole ongoing supervision of offenders. The percentage of offenders who continue for a third year is 54% of all offenders accepted and 87% of all completers. At present, there is no requirement to return to court at the conclusion of the treatment period to review the suitability of completion on an individual basis. Similarly, there is no provision for continuation past the end of treatment date. In instances in which maintenance therapy is desirable in the view of the Director, this cannot be provided.

Recommendation 7: A provision should be implemented requiring a report by the Program Director to court to review the completion status and simultaneously the need for individual ongoing maintenance therapy past the end of treatment date.

The outcomes of this evaluation are positive regarding the effectiveness of treatment. The availability of the program should be increased to all sectors of the community. Recent investigations in New South Wales have highlighted the need for effective interventions in the Aboriginal community. The rate of referrals to Cedar Cottage by Aboriginal offenders can be increased.

Recommendation 8: Funds should be allocated to support the full-time hire of an Aboriginal clinical practitioner to address the needs of Aboriginal referrals.

Recommendations regarding future evaluation and research

The coding instrument developed to audit data from Cedar Cottage records includes a substantial number of the items required to compute static offender risk scores and some of the dynamic risk scores required by the Violence Risk Scale for Sexual Offenders (VRS-SO). Additional auditing of the records can be conducted without securing additional ethical clearance or approval as this requires no contact with the offenders. An audit of a file of an offender who completed treatment requires an average of 3-5 hours; an audit of a file of an offender declined treatment requires an average of 1-2 hours. These data will permit the inclusion of the remaining dynamic items to scores offenders on all items of the VRS-SO. Use of a psychometrically designed risk assessment such as the VRS-SO instrument suited to this population may be of assistance in assessing the effectiveness of treatment, i.e., by determining whether this instrument is a valid and reliable predictor of recidivism for intrafamilial offenders in this community sample. If so, by administering the instrument at the commencement and the conclusion of treatment, an assessment can be made of the extent to which treatment reduces the risk of recidivism in this sample.

Recommendation 9: The funding necessary to cover the costs of research assistance to audit the treatment files to extract information to assess the records retrospectively using the VRS-SO should be provided.

The focus of the current evaluation was on reoffending rates. Future research is needed to examine in more depth the outcomes of the Cedar Cottage Program for victim and family members.
**Recommendation 10:** Funds should be set aside for a systematic examination of program outcomes for family members and victims.

The Cedar Cottage Treatment Program appears to provide substantial cost savings in a cost-effective manner, compared to custodial treatment program for sex offenders. However, a full analysis of cost-effectiveness of the program was not included in this evaluation. Accordingly, no conclusive determination can be made regarding the cost-effectiveness of the NSW Pre-Trial Diversion Program for Child Sexual Offenders. Given the reduction in reoffending rates, the efficiency of the treatment should be measured in direct annual costs or expenses per offender, but also in terms of the psychological costs (of former victims, future victims, relatives and other involved persons).

**Recommendation 11:** Funds should be set aside to undertake a systematic cost-effectiveness study of the NSW Pre-Trial Diversion Program for Child Sexual Offenders.

**Summary**

A decade ago, expert international consensus existed that criminal sanctions may reduce recidivism only when a treatment component is added (Howells & Day, 1999). The findings in this evaluation confirmed that compared to traditional criminal sanctions, the treatment components offered at Cedar Cottage are effective at reducing recidivism. A distinctive feature of this community-based treatment program that sets it apart from most other rehabilitative treatment programs is the provision of treatment to victims and their families in addition to the offenders. Thus, the rehabilitation of offenders through the Cedar Cottage program “offers policy makers a constructive opportunity to enhance community safety,” (Howells & Day, 1999, p.6).

At the conclusion of the qualitative evaluation of the Cedar Cottage pilot program conducted in 1992, the independent evaluator noted that the “benefits of such an apparently successful program could be made available to a larger number of abuse victims, their families and the perpetrators of abuse,” (Vinson, 1992, p. 59). The strong relationship between acceptance of responsibility and decreased reoffending which was demonstrated in this quantitative evaluation provided a further basis to endorse that recommendation.
REFERENCES


New South Wales Legislative Assembly Hansard, NSW Legislative Council, 18 November 1992.


Vinson, T. (1992). *An evaluation of the NSW Pre-Trial Diversion of Offenders Program (Child Sexual Assault)*. Unpublished report to the NSW Pre-Trial Diversion Program Board of Management. Sydney, NSW:


THE NSW PRE-TRIAL DIVERSION OF OFFENDERS (CHILD SEXUAL ASSAULT) PROGRAM: AN EVALUATION OF TREATMENT OUTCOMES

APPENDICES TO THE EVALUATION REPORT

Appendix A: Information about Cedar Cottage for Offenders .............................................................130
Appendix B: Pre-Trial Diversion of Offenders Program Policy Document ..................................................132
Appendix C: Sample Treatment Agreement ..........................................................................................178
Appendix D: Orientation Information for Program Participants who have Sexually Abused Children 182
Appendix E: Response of the Board of Management of the NSW Pre-Trial Diversion of Offenders Programme (Child Sexual Assault) to the Evaluation Conducted by Professor Tony Vinson December 1991 – May 1992 .................................................................................................................................216
Appendix F: Protocol for Sex Offender Survey Project ...........................................................................226
Appendix G: Family Reunification Coding Instrument .............................................................................238
Appendix H: Family Reunification Coding Instrument for Treatment Progress .......................................243
Appendix I: Expanded Disclosure Data Collection Sheet ........................................................................244
Appendix J: Results of Inter-rater Reliability Statistical Tests ..................................................................246
Appendix K: Abstracts of Research Theses Related to the Evaluation Project .........................................248
**THE PROGRAM**

The Pre-Trial Diversion Program which operates in NSW is an innovative Treatment Program for the protection of children. It began operation in 1989 and is run by the NSW Department of Health.

The Pre-Trial Diversion Program allows for certain categories of child sexual assault offenders to be diverted from the criminal justice process into a two year Treatment Program. The diversion occurs after charges have been filed but before the matter proceeds to conviction or entry of judgement. A conviction is recorded after the offender has been assessed “suitable” and enters an Undertaking at the District Court to participate.

During the two years, the offender is bound by the conditions of the Treatment Program. If the offender breaches these conditions, he will be returned to the criminal justice system for sentencing. If the offender completes the program successfully no further action against him will take place.

Pre-Trial Diversion is an alternative form of prosecution which attempts to increase the effectiveness of the criminal justice system. Its goals are the protection of children and the prevention of further child sexual assault in families where this has occurred.

The specific objectives of the Treatment Program are:

- To help child victims and their families receive 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;
- To stop child sexual assault offenders from repeating their offences.

**WHO IS ELIGIBLE?**

The Treatment Program is open to a limited number of child sexual assault offenders. These offenders must:

(i) satisfy an eligibility test based on certain criteria; and

(ii) demonstrate suitability for treatment at an assessment conducted by the Director of the Pre-Trial Diversion Program.

The eligibility criteria assessed by the Office of the Director of Public Prosecutions are:

- that the child victim(s) is under the age of 18 when the matter is first brought before the Court;
- that the person considered is the child’s parent, step-parent or parent’s de facto spouse;
- that the child sexual assault offence for which the person is being considered was not accompanied by acts of violence to the victim or a third party;
- that the offender is over 18;
- that the offender does not have a previous conviction for a sexual assault offence;
- that the offender has not been offered the Treatment Program before;
- whether a vacancy exists in the Treatment Program.

If an offender meets these criteria he is then assessed by the Director of the Treatment Program who will decide whether he is suitable to be accepted into the Program.

The assessments by the Director of the Program, or a person to whom the Director delegates the duty, will consider:

- whether participation in the Program by the offender concerned is in the best interest of the child;
- whether the offender accepts responsibility for his behaviour;
- whether the offender demonstrates some understanding of the impact of his behaviour on the victim and other family members;
- whether the offender has sufficient communication skills to participate in the Program.

In making a decision about an offender’s suitability for the Treatment Program, the Director’s paramount concern will be the interests of the child victim.

Services are offered to all family members including non-offending parent, child victims and siblings. Participation by any of these persons is not a requirement of the Program.

*While offenders are referred to here as “he”, the Program is open to male and female offenders.*

**CONDITIONS OF THE PROGRAM**

An offender who is admitted to the two-year program will have to sign an agreement which outlines its conditions. These include:

- The offender must move out of the home in which his children live and not return unless or until the Director of the Treatment Program approves.
- The offender may not live in any place where there are children under 16. The Director must approve the offender’s living arrangements and the offender must agree to accept visits to his place of residence by supervisory staff employed by the Treatment Program.
- The offender will not be allowed contact with his victim or other children without the written permission of the Director. “Contact” includes telephone calls, mail and messages via third parties and giving gifts.
- The offender will not be permitted to visit his victim’s home without the written permission of the Director.
- The offender must not act violently towards, threaten or harass his children, his spouse/de facto spouse, or Treatment Program staff.
- The offender must attend all therapy sessions scheduled by the Director. He may not attend under the influence of any illegal drugs or alcohol.
- If the offender commits any further sexual offences while taking part in the Treatment Program he will be suspended immediately.
- The offender must keep confidential the names of other offenders and their families in the Treatment Program.
• The offender must agree to observe any other reasonable conditions or directions imposed by the Director.

• The offender will be suspended from the Treatment Program if, in the assessment of the Director, he is not progressing.

An offender who fails to comply with any of these conditions will be suspended from the Treatment Program and returned to the normal court processes for trial. If suspended from the Treatment Program an offender will be in breach of his Undertaking and liable to immediate arrest without warrant.

THE TREATMENT

The principles on which the Treatment Program is based are:

• The offender must take responsibility for his actions. The first step in this process is to plead “guilty” to the criminal charge/s.

• The safety of the child victim is of paramount importance in treatment decisions about contact between offender and child, the timing of family therapy and the appropriateness of family reunification.

• The mother is not responsible for her partner’s abuse behaviour. Since, however, child sexual assault severely damages the mother-child bond, treatment will aim to build this bond.

• All family members shall be offered the assistance of the Treatment Program so that they may receive help to resolve their own emotional reactions and are better able to help and support the child.

• Although some families may wish to reunite, this is not a pre-requisite for joining the Program.

To achieve its aims, the Program employs a number of tested treatment methods selected from clinical experience in the child sexual assault field.

Group Treatment

Group Treatment is a very important component of the Program. Groups which operate include:

• Offender groups
• Non-offending parent groups
• Children’s groups
• Mother and children groups

Family Therapy

Family therapy is used at appropriate stages of the Program. Family therapy includes work with different parts of the family such as the mother and victim or siblings or parents. The whole family is seen together only when this is in the victim’s interests and is necessary to achieve certain treatment goals.

Individual Counselling

Individual counselling is offered to family members throughout the Treatment Program. Offenders are required to attend a minimum of once weekly for individual or group therapy.

WHAT ARE THE OFFENDER’S RIGHTS UNDER THE ACT?

An offender who completes the Treatment Program will not be sentenced for the child sexual offence(s) for which the offender has been convicted. An offender may be released from his undertaking given to the Court. However, he will then be sentenced. Notice of progress in treatment is provided to the offender at regular intervals and opportunity provided to address any aspects of unsatisfactory progress (if present).

HOW TO APPLY

An offender who wishes to participate must apply. This is done in the Local Court after being charged. Enquiries are also welcome at the Program at any time.

The New South Wales Pre-Trial Diversion of Offenders Program (child sexual assault)

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A NSW Health Department Service
Appendix B: Pre-Trial Diversion of Offenders Program Policy Document

PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM
POLICY DOCUMENT

1. Introduction and background 1
2. Department of Community Services 4
3. N.S.W. Police Service 7
4. Attorney-General's Department 9
5. Office of the Director of Public Prosecutions 10
6. Department of Health 13
7. Appendices 22

1. Act
2. Regulation
3. Brochure
1.1 **Introduction**

The NSW Pre-Trial Diversion of Offenders Program (Cedar Cottage) is a specialist counselling service for parental incest offenders, their child victims and families.

Goals of the program include:

(i) Protection of children.

(ii) Prevention of re-offending.

(iii) Prevention of further child sexual assault in families where this has occurred.

(iv) An increase in responsible thinking and behaviour by offending parents.

The program has a statutory base, the Pre-Trial Diversion of Offenders Act 1985 ("the Act"). In addition to the purpose of direct service provision, the program is committed to the expansion of knowledge and skills in the fields of sexual assault services and offender rehabilitation.

Central to the operation of the program is the principle of protecting and promoting the rights and interests of children.

1.2 **Background**

Following research and development planning, then training of key staff, Cedar Cottage began operation in 1989. The primary responsibility of the program is to provide direct services as enabled by the Act (amended April 1993), most notably to assist children who have been sexually assaulted by a parent, step-parent or de-facto partner of their parent (referred to in this document as “offending parent”).

Child sexual assault by a parent creates substantial difficulties for the child assaulted. In addition to the complex impacts upon the physical and psychological health of the child, there are a range of effects likely for other individuals within the family and upon their relationships with each other.

It is difficult to deliver effective assistance where the offending parent remains in the family. This occurs most often where the offending parent denies, in part or whole, allegations of child sexual assault. There are also false perceptions that sexual assault of children within families is somehow different, one of those differences being that it is more manageable.
The program has been created to address these difficulties by operating within a statutory framework which provides incentives for the offending parent to admit guilt and commence mandated therapy. Incentive offered to the offending parent is to avoid imprisonment. Participation in the program also provides incentive for the offender to take constructive steps to assist his or her child victim(s) by validating her, his or their experience(s) of abuse, outline details of his planning, committing and covering up the abuse, thereby opening the way to validate the experience of each family member and assist their recovery. The offending parent is provided with an opportunity to demonstrate he or she is accepting responsibility. In so doing, he or she is required to attend to issues of the ongoing safety of children in his presence or care, ie: minimise the possibility of re-offence.

Services are delivered by a range of individual, group and family therapy (where appropriate). Therapy for offending parents is separate from that of other family members. It does not involve face to face meetings between the offending parent and child victim unless it is in the interest of the child victim for this to take place and the child is safe and wishes such a meeting to take place. All offending parents must be living separately from the child victim (and other children) to commence treatment.

A secondary function of Cedar Cottage is to provide consultation and training to government service providers, agencies and community groups. By doing this, the program occupies a unique place in the network of service providers in NSW.

1.3 **Broad Goals**

(i) Child protection.

(ii) Addressing the harm caused to individuals and relationships: child, mother, siblings and extended family.

(iii) Preventing re-offending and future harm.

(iv) Community safety.

(v) The provision of an incentive for the person who has sexually offended to accept responsibility.

Family reunification is not a goal of the program. The offender must live separately from the family initially and have no contact with children. Where families choose to reunite, the Program actively participates in the decision making and any steps taken in this direction.
1.4 Principles include:

(i) A person who sexually abuses is 100% responsible for his or her abusive actions. The child victim is never to blame nor is the non-offending parent responsible for the abusive conduct of their partner.

(ii) Sexual abuse is planned controllable behaviour.

(iii) Sexual abuse is perpetrated for the offending person’s self gratification.

(iv) Strengthening of the mother/child victim relationship is a key element in the child protection and in the recovery process.

(v) A significant tactic in setting up the context for abuse is to undermine the mother/child victim relationship which must be addressed by the Program.

(vi) The principal goals of treatment of the offending parent is relapse prevention and victim restitution.

(vii) Offenders are expected to demonstrate they are accepting responsibility for their actions in ways which include:

- Relieving others of their burdens such as guilt, blame, sense of responsibility.
- Assisting those who have been harmed for example by providing practical assistance and answers to questions.
- Facing up fully to other irresponsible practices.
- Developing a responsible explanation for his or her choice to sexually abuse a child or children.
- Developing and putting in place a relapse prevention plan.
1. **DEPARTMENT OF COMMUNITY SERVICES**

2.1 The Department of Community Services (DoCS) is mandated by the Children and Young Persons (Care and Protection) Act 1998 (CYPCPA) to ensure the safety, welfare and wellbeing of children. This is achieved by the investigation and assessment of reported allegations of child abuse. DoCS may then organise services to protect children and their families from further abuse or future harm.

When there is a belief that a child is ‘at risk of harm’ a report should be made to the DoCS Helpline. Certain professionals, specified in the CYPCPA, must report a child they believe is at risk of harm. After the DoCS Helpline has completed an initial assessment of the reported allegations they will recommend either no further action be taken as the child is not deemed to be in need of care and protection, or that an assessment of risks should occur.

DoCS may undertake an investigation to assess allegations of sexual abuse perpetrated upon a child or young person. This investigation will include an assessment of risk within the family. The response will be provided by either the Joint Investigation Response Team (JIRT), or by the local Community Service Centre (CSC), in conjunction with the NSW Police Service.

After the investigation, decisions will be made about the continued DoCS involvement, based on the assessed risk for the child. If ongoing interventions are required, the DoCS role becomes one of service co-ordination in the context of case management.

If a child cannot be protected within the family, further interventions may be undertaken by DoCS including:

- Organising for a voluntary Out of Home Care placement (s151 CYPCPA),
- Initiating a care application (s61 CYPCPA) and/or other Children’s Court proceedings (Chapter 5 CYPCPA), or
- Referring to other services, and providing information or advice.

When the child is no longer at risk and there are no outstanding actions for the case plan, DoCS will close the case. Unless the child is considered to be no longer at risk, DoCS will continue to manage the case.

2.2 When a person is referred to the Pre-Trial Diversion Program for assessment, the program staff will communicate this information to the DoCS Helpline. The Helpline will forward this information onto the appropriate office/caseworker, if the case is still active. If the case has been closed, the information is recorded on the child’s KiDS history and is retained by the Helpline.
Staff at the Pre-Trial Diversion Program may liaise with the investigating DoCS office regarding the information contained in the brief of evidence compiled by the NSW Police Service. Any requests made by staff of the Pre-Trial Diversion Program that relate only to the offender, not the welfare of the victim, cannot be actioned by DoCS. Information that DoCS staff may release to the Pre-trial Diversion Program is governed by s248 of the CYPCPA. Requests for information that do not relate to the safety, welfare or wellbeing of a child do not fit the criteria for the exchange of information within the meaning of the CYPCPA.

DoCS caseworkers are not authorised to release information regarding disclosures made by a child or the child’s / family circumstances when they do not relate to the child’s safety, welfare or well being. Written permission provided by a family does not circumvent this provision of the CYPCPA. Such information is more appropriately released by the court dealing with the offender’s case.

If a matter relating to the protection of a child is proceeding through the Children’s Court, the staff of the Pre-Trial Diversion Program may make a representation directly to the Magistrate to request the release of any evidence that has been provided to the Court.

2.3 Information about a person’s acceptance into the Pre-Trial Diversion Program may be used by DoCS to inform any ongoing casework for the child or any Children’s Court proceedings that may occur.

Information regarding a person’s participation in the Pre-trial Diversion Program may be used by DoCS to inform any contact plans being considered. Where Children’s Court proceedings have been initiated by DoCS, relevant information about contact should be made available for the Court by staff of the Pre-trial Diversion Program, if a contact order has been requested under s86 of the CYPCPA. This information will allow the Court/DoCS to assess the appropriateness of access and the child’s safety and welfare needs.

2.4 DoCS will continue to manage a case whilst there are concerns for the safety, welfare and well being of a child. When an investigation is completed and DoCS no longer regard a child as being ‘at risk’, DoCS is required to close a child protection case. The Pre-trial Diversion Program may continue to inform DoCS of a participants progress by making reports to the Helpline and this information will be recorded on the child’s KiDS history. If program staff members have concerns for a child and believe a child may be ‘at risk’ then a report should be made to the Helpline for further action.

2.5 When a program participant has completed the Pre-Trial Diversion Program and has expressed a wish to return to the family home, a report should be made to the Helpline. The report should inform DoCS that a participant is considering returning to the family and that
the person has previously posed a risk to a child. Any concerns regarding possible threats to a child’s safety should be expressed to DoCS staff at this time.

When undertaking an assessment regarding the participant’s possible return to the family, DoCS will liaise with the child, the family, the Pre-trial diversion Program, the child’s sexual assault counsellor and other relevant agencies. The assessment will attempt to evaluate any possible future risk for the child and the family posed by the participant’s return to the family
3. **NEW SOUTH WALES POLICE SERVICE**

The role of NSW Police in child protection is to recognise, report and investigate child abuse and neglect, and initiate legal proceedings for child abuse and neglect offences under the Crimes Act 1900 and the Children and Young Persons (Care & Protection) Act 1998. The Police, with the Department of Community Services (DoCS), is a designated statutory authority responsible for the care and protection of children and young people, under the Children and Young Persons (Care & Protection) Act 1998. NSW Police is a designated supervising authority under the Child Protection (Offenders Registration) Act 2000 and officers may apply to the courts for an order prohibiting certain offenders who pose a risk to the lives or sexual safety of children from engaging in specified conduct under the Child Protection (Offenders Prohibition Orders) Act 2004. Police are also the designated authority for applying for apprehended violence orders on behalf of children (and young people as required) under section 562C(3) of the Crimes Act 1900. Police assist with ensuring the safety and security of children and young people, their families and the workers in agencies involved in child protection intervention.

3.1 Prevention and Proactive Policing

All Police officers are mandatory reporters and have responsibility to notify the DoCS Helpline when a child or young person is considered at risk of harm.

Specialist Police, such as Youth Liaison Officers, Domestic Violence Liaison Officers and officers attached to the Police and Community Youth Clubs play an important role in the care and protection of children as part of their everyday specialist role. If they consider a child or young person to be at risk of harm then a report is made to the DoCS Helpline.

Under the Child Protection (Offenders Registration) Act 2000 people who have been convicted of certain offences against children are required to keep Police informed of where they live and work, what vehicles they drive and whether they have unsupervised contact with any children. A local Police officer is assigned as a Case Manager to whom the registrable person is required to report. The Case Manager has responsibility for ensuring the registrable person is complying with his or her reporting obligations under this Act. The Child Protection Registry in the Child Protection & Sex Crimes Squad (CP&SCS) coordinates police responsibilities under this Act.

3.2 The Investigation of Child Maltreatment

The CP&SCS is the Police Service focal point for the investigation and management of allegations of child abuse and neglect. Twenty-one Joint Investigation Response Teams (JIRTS) are located throughout the state and are staffed by specialist child protection investigators. There are nine JIRTS in the Sydney, Newcastle and Wollongong areas.
comprising co-located specialist Police investigators and officers from DoCS. The remaining twelve JIRTs comprise specialist Police and officers from DoCS and, although they are in non co-located environments in rural areas, their investigations are conducted jointly. JIRTs investigate allegations of sexual assault and the more serious allegations of physical assault and neglect where there is criminality. Police from the Local Area Commands investigate less serious allegations of physical assault and neglect.

The Sex Crimes Squad has the responsibility for investigating serial or networked sex offenders, child prostitution, child pornography, allegations of female genital mutilation, and sexual servitude. The Sex Crimes Squad comprises specialist child protection investigators.

Investigators attached to the Sex Crimes Squad have the responsibility of investigating allegations, arresting and charging of offenders, compiling briefs of evidence and putting before the courts the alleged offenders.

3.3 Notification of the Pre-Trial Diversion Program to Persons Charged

The case officer in matters where a person has been charged with a child sexual assault offence/s, has the responsibility of providing to the alleged offender printed information on the Pre-Trial Diversion of Offenders Treatment Program, as required by the Pre-Trial Diversion of Offenders Act 1985.

3.4 The Pre-Trial Diversion Program Inter-Departmental Advisory Board

A member of the NSW Police Service represents the Police Service and the Minister for Police on the Pre-Trial Diversion Program Inter-Departmental Advisory Board.
ATTORNEY-GENERAL'S DEPARTMENT

4.1 The Pre-Trial Diversion of Offenders Act 1985 is administered by the Attorney-General.

4.2 As indicated by Section 6 of the Pre-Trial Diversion of Offenders Act, 1985 (hereafter referred to as the Act) the Attorney General has the responsibility of determining the approved form of information to be provided to persons charged with relevant sexual offence(s). This approved form of information is set out in a brochure (refer appendix 1).

4.3 A representative of the Attorney General participates in the Inter-Departmental Advisory Board of Management.
OFFICE OF THE DIRECTOR OF PUBLIC PROSECUTIONS (DPP)

Pursuant to Section 11 of the Act, the Prosecutor shall inform the Magistrate before whom the person appears at the end of the four week remand provided for by the regulations, of the person's eligibility for assessment by the Program. Where it has been determined that the alleged person is eligible, the proceedings are further adjourned for a period not exceeding eight weeks to enable the Program to make an assessment of the person's suitability for entry into the Program.

5.1 Regulations for Admission to Assessment for Program

The guidelines set out in the Regulations (Appendix 2) provide that a prosecutor should not refer a person for assessment:

a) if the child sexual assault offence with which the person is being charged is alleged to have been accompanied by acts of violence towards the alleged victim or others, or
b) if the person is under 18 years of age, or
c) if the person has a prior conviction for a sexual offence, whether in New South Wales or elsewhere, or
d) if the alleged victim is 18 years of age or more when the person first appears before a Justice in relation to the offence, or
e) if the person has previously been requested under section 23 of the Act to give an undertaking in relation to any offence.

A prosecutor may take into account any other matter that the prosecutor considers relevant to the question of whether or not the person should be referred for assessment.

5.2 Process for Referral to the Program

Immediately after the person has appeared before a magistrate pursuant to Section 13 of the Act or at any earlier time, the following document shall be supplied to the Director.

(i) A copy of the Police brief;
(ii) A copy of the person's antecedents and criminal history, if any;
(iii) Information as to the person's Bail Undertaking, including compliance with its conditions if any;
(iv) Any other information considered relevant to a determination by the Director.

The Regulations provide for the DPP to be notified in writing of the result of the assessment within one week of the assessment having been made.
5.3 Undertaking

(i) The DPP will notify the program of the date of hearing to enter Undertaking and request report to assist Court at that time.

(ii) A copy of the Undertaking including date of commencement and name of Judge will be forwarded by DPP to the Program.

5.4 Process for Program Notification of Breach and Follow-Up by DPP

In addition to the conditions imposed by the Director as part of the Undertaking given to the District or Supreme Court, the Director also has the power to require compliance with any reasonable directions imposed on the person by virtue of Section 20 of the Act. Therefore, the question of notification of a breach to the DPP arises at two points, namely between the plea of guilty having been entered before a Magistrate and the giving of the Undertaking before the District or Supreme Court, and for the duration of the Program after the Undertaking has been entered into before the District or Supreme Court.

The DPP shall be advised in writing immediately the Director is satisfied a breach of the conditions attached to the Undertaking has occurred.

To ensure that the person is bound by a condition prohibiting access to the family following suspension from the Program, a request for a Bail Undertaking will be made, in addition to and simultaneously with the Program Undertaking.

The request will be that the Bail Undertaking will include a standard condition that the person obey all reasonable directions of the Director including a direction not to approach, contact or attempt to contact the family and to attend Court at such time and place as notified by the DPP.

On suspension from the Program, the person will be in breach of this Bail Undertaking, thereby providing for immediate arrest without warrant. There is an additional power of arrest pursuant to Section 27 of the Act. The Court has the power to issue a bench warrant for the arrest of the person, directing that person to be brought before the Court as soon as possible. This power does not appear to be referable to a failure on the part of the person to appear before the Court. The Court may be satisfied in the absence of the person and on the basis of information supplied by the Solicitor that the person has failed to comply with the Undertaking, or with requirements made by or under the Act or the regulations, and on that basis alone the Court may issue a bench warrant.

On the hearing of the breach, a representative of the Program will be in attendance and will be in a position to testify to the nature of the breach by the person. The determination of the Court following the hearing will therefore automatically be known to the Program. The Program will be notified by a notice of listing addressed to the Director.
Where a person completes the Program without breaching the Undertaking, the Solicitor must be notified in writing by the Director of the discharge of the Undertaking, so that steps may be taken to close the prosecution file.
6. DEPARTMENT OF HEALTH

6.1 Description of the Program

The Pre-Trial Diversion Program takes its place within the context of an existing network of services for victims of sexual assault which has been developed since 1978 within the public health system.

This Program differs from other services in that it is based on a collaborative approach between the criminal justice system and the Program.

6.2 The Program

The NSW Pre-Trial Diversion of Offenders Program is an integrated treatment program for all members of the family including offending parent, non-offending parent and child victim(s) in which the identified child victim(s) has been sexually assaulted by a parent, parent’s spouse or de-facto partner. The Act provides for certain categories of child sexual assault offenders to be diverted from certain sentencing outcomes into a 2 to 3 year treatment program. The diversion occurs after charges have been filed but before the matter proceeds to conviction or entry of judgement. A conviction is recorded after the offending parent has been assessed as "suitable" and enters an Undertaking at the District Court to participate.

The Program is a designated supervising authority under the Child Protection (Offenders Registration) Act 2000.

This treatment program is unique in a number of respects. These include:

(i) Legislative basis providing and incentive for offending parents to plead guilty and thereby gain access to treatment. Convictions are recorded but entry into the program precludes imprisonment or other sentences provided treatment is successfully completed. Conviction on the basis of guilty plea(s) relieves the child victim(s) of giving evidence in contested matters.
(ii) Whilst applying to the criminal processes in prosecuting an offending parent, the stated purpose of the legislation is protection of children, the interests of the identified child victim(s) in particular.

6.3 Treatment Strategies.

(i) Ensure offending parent moves from the home of the victim and family;
(ii) Providing a context for recovery for victims and other family members free from the presence of offending parent
(iii) Giving clear priority given to attend to the needs of the victim and family;
(iv) Disentangling relationships within the family free from the offending parent’s influence;
(v) Exposing the role of secrecy and isolation in the abuse and providing opportunities for the victim and family to escape this.
(vi) The offending parent is expected to face up fully to himself or herself and significant others about all aspects of his or her abusive actions. These include; planning, setting up the context for abuse, ensuring secrecy, dealing with disclosure, provide a full account and extent of abuse (the offending parent must validate the child victim's account) and draw a distinction between acts of sexual abuse and his or her own or thoughts, feelings and beliefs;

(vii) The offending parent is to develop a relapse prevention plan which includes the involvement of significant others to support and maintain non-abusive practices by the offending parent;

(viii) Maintenance post expiry of legal mandate is regarded as highly desirable. The program offers voluntary “post-completion” participation for all offending parents who satisfactorily complete the mandated program.

6.4 Treatment

Treatment is based on the principle that offenders must demonstrate acceptance of full responsibility for their actions. Treatment offered to other family members is separate from that provided to offenders. Children are not brought together with offenders in treatment unless this is what they want and is supported by non-offending parent and clinical staff.

Treatment available for family members is individual counselling, group treatment (e.g. offender groups, non-offending parent groups, children's groups, mother and children's groups), family and conjoint therapy (as appropriate).

6.5 Management

The program is funded and administered by the Department of Health (NSW) and has an interdepartmental advisory management structure. That management structure includes representatives for the Minister for Health, Attorney General, Minister for Community Services, Police Service and Community Representative.

The successful operation of the Program requires a management structure that:

- ensures that the Program fulfils the requirements of the legislation in both its corrective and treatment aspects;
- facilitates co-operation between the relevant Departments;
- monitors the Program's operations.

The Director of the Program is to prepare a report annually on the operation of the Program for the Director-General of the Department of Health to forward to the Attorney General, Minister for Community Services, Minister for Police and Minister for Health.
6.6 Responsibilities of the Area Health Service

The designated Area Health Board shall oversight the administration and day-to-day functioning of the Program in accordance with policies established by the Advisory Board through a Program Manager.

The Area Health Service shall be represented on this Board of Management, by a member of the Area Executive. Area Health Service responsibilities shall include:

- employment of staff
- financial management and reporting
- provision and maintenance of premises
- other as required.

The Area Health Service shall not:

- involve Program staff or clients in service delivery, training or research undertaken by any agency or service under the administration of the Area Health Board.
- use Program funds for provision of other Area Health Services.
- develop policies or procedures concerning the operation of the Program without prior endorsement by the Advisory Board.

6.7 Referral to the Program

Persons who are assessed as eligible for the Program, under the regulations shall be referred by the Director of Public Prosecutions (DPP) to the Program. Under the Act the DPP is the only source of referral to the Program.

6.8 Assessment of Suitability for the Program

The Director or a person to whom the Director delegates the duty, shall be responsible for deciding a person's suitability for the Program. The assessment shall be based on:

- Police information about the offence/s;
- Relevant information from agencies who have been involved in the treatment of the person/the family;
Interviews with both the person and other family members. Only in exceptional circumstances will the victim be interviewed in the offending parent’s assessment for suitability.

Criteria used to assess the person's suitability are set out in the Act (s.14).

The Director's decision as to a person's suitability for the Program shall be made in consideration of the best interest of the child/ren.

The assessment shall be conducted as soon as practicable after referral. A maximum of four (4) assessments within the program will be conducted at the one time. Notice of capacity to assess persons referred is to be provided by the Director to the DPP within one (1) week of receiving the referral. The Director shall notify the DPP of the outcome of the assessment within one week of the completion of the assessment, as outlined in the Regulations under the Act.

The Director shall notify the appropriate Manager Casework of the Department of Community Services that the person has been referred for assessment and of the outcome of the assessment.

6.9 Acceptance to the Program

Following the person's acceptance by the Program, and prior to beginning treatment, the person will sign a Treatment Agreement outlining the necessary conditions of his/her participation in the Program. A copy of the Treatment Agreement shall be forwarded to the Court at the time an offending parent enters an Undertaking pursuant to s.23 of the Act.

Where a person fails to comply with any of the conditions of this Agreement, the Director shall immediately notify the DPP by telephone that the person is suspended from the Program. This will be confirmed in writing within one week.

A detailed report of this failure to comply shall be supplied to the DPP as required.

The relevant Case Manager of the Department of Community Services and the Case Officer of the Police Service shall be notified immediately of the person's suspension from the Program.

6.10 The Process

The treatment model outlined is based on the assumption that a systemic orientation to therapy will be utilised.
A variety of treatment modalities will be used in order to achieve the objectives of the Program. They have been selected on the basis of clinical experience in this area.

Group Treatment

This is a very important component of the Program. A range of groups operate during the Program including: offending parent groups, victim groups, mother and victim groups, parent groups, etc. Offending parent groups are conducted on a fortnightly basis. Other groups are conducted at times convenient and appropriate to needs of clients. All groups have clear goals.

Offending Parents

The goals in offending parent groups are to:

- facilitate the person fully accepting responsibility for his/her behaviour;
- facilitate the person to develop empathy for his/her victim;
- alter the person's framework for regarding his/her own behaviour such that he/she will regard sexually abusive behaviour towards children as totally unacceptable.
- facilitate the person demonstrating change in addition to stated change(s).

Mothers and Child Victims.

The goals of mother and victim groups are to:

- develop a supportive network;
- reduce stigmatisation;
- develop new interactive skills, e.g. becoming more assertive;
- facilitate their empowerment.

Education on the nature of sexual offending tactics of offenders and matters related to risk of reoffence are incorporated into the group program for mothers and child victims.

Family Therapy

Family therapy will be used during the Program as indicated. Family therapy will include dyad therapy, e.g., working with the marital couple, mother-victim work, etc. This component is particularly important in achieving the following;
- providing a forum in which the family members are able to discuss the assault and the issues that arise from it;
- changing the power structure in the family;
- ending the pattern of secrecy in the family.

Individual Therapy

Individual therapy is offered to family members at appropriate points during the treatment process. Child victims and mothers are offered individual therapy or liaise with other service providers if this is more suitable to their needs.

Individual therapy is provided to all offenders on a fortnightly basis or more often if required.

Small Group Therapy

As an alternative to individual therapy, offending parents may receive intensive personal therapy in small groups of up to three participants.

6.11 Review mechanisms

The corrective emphasis of the Program makes it essential that the progress of all offending parents and the effectiveness of the Program are regularly monitored and reviewed. This includes:

- A formal review of every offending parent and his or her family's progress at least every four months. This involves all clinical staff and representatives of other agencies if appropriate, and is be chaired by the Director or Co-ordinator of Clinical Services. A written report is provided at each review.
- Regular supervision and peer review for all staff to ensure that high clinical standards are maintained.
- Visits to the offending parent's place of residence, as required, arranged by the Director of the Program, to check that the offending parent is complying with the residence conditions of his or her Treatment Agreement.
- Progress in therapy to be demonstrated and assessed by each offending parent from each therapy session to the next.
6.12 Recording and Data Collection

Adequate records shall be kept by the Program. This includes a record of the offender's attendance at the Program, requests which need to be approved by the Director, records of home visits to check place of residence, and details of violations of the Treatment Agreement. Data shall be collected in a manner consistent with the needs of the research projects being, or may be, undertaken.

6.13 Program Staffing

Clinical Staff

- Program Director,
- Co-ordinator of Clinical Services,
- Treatment Co-ordinators, 1 Full-time, 4 Part-time (28 hours/week). (Treatment Co-ordinators x 4 Full-Time Equivalent)

For each offending parent and family in the Program, the Co-ordinator of Clinical Services will nominate one of the clinical staff as Family Case Manager. The Treatment Co-ordinator will be responsible for treatment planning and co-ordination, and reporting progress and any violations of the Treatment Agreement to the Director.

Clerical Staff, Two (2) (Full-Time Equivalent).

Sessional Staff

Consultants with specialist skills may be employed from time to time to contribute to the development of various aspects of the Program.

Investigatory Staff may be employed or contracted as required to ensure the offending parent’s compliance with conditions of his or her Treatment Agreement.

6.14 Throughput

This is an intensive therapeutic Program, treating not just the offending parent, but other family members. Each offending parent and family members who choose to participate, will participate in separate group therapy session, plus individual, dyad, and family sessions as required.
Assessment of the suitability of offending parents for the Program needs to be thorough. It requires a minimum of eight (8) interviews per family, involving two clinical staff.

Given the nature of the Program, adequate time needs to be allowed for staff training, supervision and ongoing program development.

Allowance must be made for the clinical staff to prepare reports and to appear in Court in the event of violations of the Treatment Agreement; and to keep comprehensive records as required in light of the corrective nature of the Program.

On the basis of these considerations, an intake at any one time of 18-20 offenders and their families is considered optimal for the operation of the Program. Capacity of the program may vary depending upon a number of variables such as the number of clients who may seek assistance in relation to any single offending parent, the intensity of services required, the level and relative experience of staff available at the Program.

This represents 120 - 150 clients in the Program at capacity. A clinical staff ratio to offending parents should not exceed 1:5.

A further consideration is the provision of ongoing maintenance therapy to offending parents “in recovery” and other family members after offending parents have completed formal participation.

The program is also used as a centre for consultation and training of others. This should also be taken into account when considering throughput.

6.15  Budget

A budget allocation shall be made by the Department of Health annually to support the Program. The budget shall be administered by the Area Health Service which has entered into the service contract with the Department of Health.

6.16  Physical requirements of the Program

The Program is located in the Sydney metropolitan area, in an area which is central and easily accessible by public transport.

Ongoing physical requirements of the Program include the following:

- The preferred physical facility is a house. A house is favoured because it creates a more informal atmosphere. This is more comfortable for the clients of the Program, especially victims.
• Given community sensitivity to the issue of child sexual abuse, attention needs to be given to the issues of community acceptance and security when selecting a location.

• Adequate groupwork rooms, family interviewing rooms and office space. Office space is not to be utilised for interviewing.

• One-way screens for supervision and training.

• Video equipment. This is used in therapy, supervision and training.

• Office furnishings and therapist equipment.

• Separate entrance and waiting areas for offending parents as distinct from other family members.

• Separate space for staff away from all client areas.
APPENDIX 1

PRE-TRIAL DIVERSION OF OFFENDERS ACT 1985 No. 153

[Reprinted as at 12 July 1990]

UPDATED 5 SEPTEMBER 1995

NEW SOUTH WALES

[STATE ARMS]

TABLE OF PROVISIONS

PART 1—PRELIMINARY

1. Short title
2. Commencement
2A. Purpose of Act
3. Definitions
3A. Persons to whom Act applies
4. Act not to apply to certain persons
5. Justices Act 1902 to apply

PART 2—SPECIAL PROCEDURE BEFORE COURTS

6. Information relating to the Program etc. to be given to person charged
7. Person appearing before Justice may request that Act not apply
8. Director of Public Prosecutions to conduct prosecutions
9. Proceedings to be adjourned pending decision by prosecutor
10. Matters to be considered by prosecutor in deciding whether to refer person for assessment
11. Prosecutor to notify Justice of decision
12. Act ceases to apply to person not referred for assessment
13. Proceedings to be further adjourned pending assessment
14. Assessment
15. Prosecutor to notify Justice as to person's suitability
16. Act ceases to apply to person not suitable for participation in the Program
17. Act ceases to apply if person does not plead guilty before Justice
18. Act ceases to apply if plea of guilty rejected
19. Certain child sexual assault cases may not be disposed of summarily
20. Person pleading guilty before Justice to comply with certain directions pending appearance before higher court
21. Act ceases to apply if person does not comply with directions pending further appearance
22. Act ceases to apply if person does not plead guilty before Supreme Court or District Court etc.

PART 3—UNDERTAKING TO ATTEND PROGRAM, ETC.
23. Undertaking to attend the Program to be given to Court
24. Procedure following giving of undertaking
25. Person may be released from undertaking
26. Breach of undertaking etc.
27. Requirement to appear or issue of warrant on breach
28. Powers of court on breach
29. Court may be constituted by another judge
30. Person who has complied with undertaking not to be further prosecuted etc.

PART 3A—PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM

30A. The Program

30B. Administration of the Program

PART 4—MISCELLANEOUS

31. (Repealed)

32. Certain defects not to invalidate proceedings

33. Evaluation of administration of Act

34. Regulations

Savings and transitional provisions

SCHEDULE 1—SAVINGS AND TRANSITIONAL PROVISIONS

____________________________________________
An Act to establish a procedure whereby child sexual assault offenders may be diverted from the criminal process into a treatment program.

PART 1—PRELIMINARY

Short title

1. This Act may be cited as the Pre-Trial Diversion of Offenders Act 1985.

Commencement

2. (1) Sections 1 and 2 shall commence on the date of assent to this Act.

   (2) Except as provided by subsection (1), this Act shall commence on such day as may be appointed by the Governor and notified by proclamation published in the Gazette.
Purpose of Act

2A. The purpose of this Act is to provide for the protection of children who have been victims of sexual assault by a parent or a parent’s spouse or de facto partner. The Act provides for the establishment of a program administered by the Department of Health. In the implementation of the Act, it is intended that the interests of a child victim are to prevail over those of a person pleading guilty to a charge of sexual assault in relation to the child.

Definitions

3. (1) In this Act, except in so far as the context or subject-matter otherwise indicates or requires:


``Director'' means the person nominated by the Director-General of the Department of Health to be Director of the Program;

``Justice'' means a Justice of the Peace;

``Program'' means the Pre-Trial Diversion of Offenders Program approved in accordance with Part 3A;

``regulations'' mean regulations made under this Act.

(2) A reference in the definition of ``child sexual assault offence'' in subsection (1) to an offence under a specified provision of the Crimes Act 1900 that has been amended or repealed is, or includes, a reference to an offence mentioned in the provision as in force before the amendment or repeal.

Persons to whom Act applies

3A. This Act applies to a person who is charged with a child sexual assault offence committed with or upon the person’s child or the child of the person’s spouse or de facto partner.
Act not to apply to certain persons

4. (1) This Act does not apply to a person in relation to a charge for a child sexual assault offence:

(a) if the person was charged with that offence before the commencement of this Act; or
(b) if the person is required to appear in respect of the charge before the Children's Court.

(2) For the purposes of subsection (1) (a), a person shall be regarded as having been charged with an offence if a summons to appear before a Justice in respect of the offence has been served on the person.

Justices Act 1902 to apply

5. Except as provided by this Act, the Justices Act 1902 shall apply to and in respect of a person charged with a child sexual assault offence.

PART 2—SPECIAL PROCEDURE BEFORE COURTS

Information relating to the Program etc. to be given to person charged

6. A person to whom this Act applies who is charged with a child sexual assault offence shall, as soon as practicable after being charged, be furnished, in a manner approved by the Attorney General, with information regarding the operation of this Act.

Person appearing before Justice may request that Act not apply

7. (1) Where a person who appears before a Justice in relation to a charge that the person has committed a child sexual assault offence makes a request to the Justice that this Act cease to apply to the person, this Act shall cease to apply to the person in relation to that charge.

(2) A request referred to in subsection (1) may be made at any stage of proceedings before a Justice relating to a child sexual assault offence.

Director of Public Prosecutions to conduct prosecutions
8. The prosecutor in any proceedings in which this Act applies to a person shall be the Director of Public Prosecutions, or a person authorised for the time being by the Director of Public Prosecutions in relation to the proceedings.

Proceedings to be adjourned pending decision by prosecutor

9. Where a person to whom this Act applies first appears before a Justice in relation to a child sexual assault offence, the Justice shall adjourn the proceedings for such period, not exceeding the period prescribed for the purposes of this section, as the prosecutor may request to allow for a determination to be made as to whether the person is to be referred for assessment in relation to the person's suitability for participation in the Program.

Matters to be considered by prosecutor in deciding whether to refer person for assessment

10. In determining whether a person charged with a child sexual assault offence is to be referred for assessment in relation to the person's suitability for participation in the Program, the prosecutor must:

   (a)   consider the guidelines set out in the regulations; and

   (b)   ascertain from the Director or a person to whom the Director delegates the function whether a place in the Program would be available for the person if the person were to give an undertaking to participate in the Program.

Prosecutor to notify Justice of decision

11. (1) Where a person to whom this Act applies appears before a Justice following any adjournment of the proceedings under section 9, the prosecutor shall inform the Justice as to whether the person is to be referred for assessment in relation to the person's suitability for participation in the Program.

   (2) The prosecutor is to inform the Justice that the person is not to be referred for assessment if the prosecutor has ascertained under section 10 that a place in the Program would not be available for the person if the person were to give an undertaking to participate in the Program.
Act ceases to apply to person not referred for assessment

12. Where, under section 11, the prosecutor informs the Justice that a person charged with a child sexual assault offence is not to be referred for assessment in relation to the person's suitability for participation in the Program, this Act shall cease to apply to the person in relation to that charge.

Proceedings to be further adjourned pending assessment

13. (1) Where a Justice before whom a person charged with a child sexual assault offence appears is informed by the prosecutor that the person is to be referred for assessment in relation to the person's suitability for participation in the Program, the Justice shall adjourn the proceedings for such period, not exceeding the period prescribed for the purposes of this section, as the prosecutor may request to allow for that assessment to be made.

(2) Proceedings may be adjourned more than once under this section but the periods for which the proceedings are adjourned shall not, in total, exceed the period prescribed for the purposes of this section.

Assessment

14. (1) A person who is to be referred for assessment in relation to the person's suitability for participation in the Program must be referred for assessment, and be assessed, in accordance with the regulations.

(2) The Director, or a person to whom the Director delegates the duty, is to assess a person's suitability for the purposes of subsection (1) and in doing so may take into account any or all of the following matters which appear to be relevant and any other matter which he or she considers to be relevant:

a) any statement made to a police officer in relation to the alleged offence (including statements of the person charged with the offence, the child concerned, a parent of the child or any other person with relevant information);

b) relevant information held by other government agencies which are or have been involved in the treatment of the person charged with the offence or of a member of that person's family or household;

c) interviews conducted by the Director or officer making the assessment with the person, the person's spouse or de facto spouse and the child concerned;

d) whether the person accepts responsibility for the sexual assault of the child;
e) whether the person demonstrates some understanding of the impact of the offence on the child and on other members of the child's family or household;

f) whether the person's spouse or de facto partner is prepared to participate in the Program as required by the Director;

g) whether the person and the person's spouse or de facto partner have sufficient interactive skills to be able to participate in any group therapy aspects of the Program;

h) whether the person and the person's spouse or de facto partner agree to participate in all aspects of the Program;

whether participation in the Program by the person, the person's spouse or de facto partner and the child concerned is in the best interests of the child.

(3) The prosecutor is, in accordance with the regulations, to be notified as to the result of the assessment and to be provided with written reasons if the assessment made is that the person is not suitable for participation in the Program.

Prosecutor to notify Justice as to person's suitability

15. Where a person to whom this Act applies appears before a Justice following any adjournment of the proceedings under section 13, the prosecutor shall inform the Justice as to whether the person has been assessed as being suitable for participation in the Program.

Act ceases to apply to person not suitable for participation in the Program

16. Where, under section 15, the prosecutor informs the Justice that a person charged with a child sexual assault offence has been assessed as not being suitable for participation in the Program, this Act shall cease to apply to the person in relation to that charge.

Act ceases to apply if person does not plead guilty before Justice

17. (1) Where:

   a) a person to whom this Act applies appears before a Justice following any adjournment of the proceedings under section 13 and is charged with a child sexual assault offence (whether or not that offence is the offence originally charged); and
   
   b) the prosecutor informs the Justice that the person has been assessed as being suitable for participation in the Program,

the person shall, before any evidence is given in those proceedings, be asked to plead to the charge.
(2) Where, upon being asked to plead to a charge as referred to in subsection (1), a person pleads guilty, the Justice shall, before accepting or rejecting the plea, consider:

   a) whether the person has received such advice (including legal advice) as the Justice thinks proper in the circumstances; and

   b) whether the person understands the purpose of the Program and the effect of giving undertakings under this Act,

and may adjourn the proceedings for a period, not exceeding the period prescribed for the purposes of this section, to allow that advice and information to be given to the person.

(3) Except as provided by subsection (4), where, upon being asked to plead to a charge as referred to in subsection (1), a person pleads not guilty or refuses to plead, this Act shall cease to apply to the person in relation to that charge.

(4) Where, upon being asked to plead to a charge as referred to in subsection (1), a person does not plead guilty to that charge but, instead, pleads guilty to another child sexual assault offence and the plea in respect of the other offence is accepted by the Justice:

   a) this Act shall not cease to apply to the person by reason only of the person's failure to plead guilty to the original charge; and

   b) subject to any other provision of this Act, this Act shall continue to apply to the person in respect of the offence to which the plea of guilty was made as if that offence had been the offence originally charged.

Act ceases to apply if plea of guilty rejected

18. (1) Where, upon being asked to plead to a charge as referred to in section 17 (1), a person pleads guilty, the Justice may accept or reject the plea under section 51A of the Justices Act 1902 on such grounds as the Justice would have power to do so if this Act did not apply to the person.

(2) In determining whether to accept or reject a plea as referred to in subsection (1), a Justice may consider any papers or statements tendered to the Justice but shall not require any oral evidence to be given.

(3) Where the Justice does not accept a plea of guilty made by a person to a charge in respect of a child sexual assault offence, this Act shall cease to apply to the person in relation to that charge.
Certain child sexual assault cases may not be disposed of summarily

19. If this Act applies to a person charged with a child sexual assault offence, the offence must not be dealt with summarily under Part 9A of the Criminal Procedure Act 1986 (which relates to the summary disposal of certain indictable offences unless an election is made to proceed on indictment).

Person pleading guilty before Justice to comply with certain directions pending appearance before higher court

20. A person to whom this Act applies who has pleaded guilty before a Justice to a child sexual assault offence shall, until requested by the Supreme Court or District Court to give an undertaking under this Act, comply with all reasonable directions given by the Director to the person in relation to:

a) the behaviour of the person (including access by the person to any other person or premises or place, whether or not the person has a legal or equitable interest in the premises or place);

b) the commencement by the person of participation in the Program;

c) any matter prescribed by the regulations; and

d) any other matter which the Director thinks necessary or appropriate in the circumstances.

Act ceases to apply if person does not comply with directions pending further appearance

21. Where a person to whom this Act applies who is charged with a child sexual assault offence appears before the Supreme Court or the District Court, the court may, if it is satisfied that the person has failed to comply with a reasonable direction given by the Director to the person under section 20, determine that this Act shall cease to apply to the person in relation to that charge, and that determination shall have effect accordingly.

Act ceases to apply if person does not plead guilty before Supreme Court or District Court etc.

22. (1) Except as provided by subsection (2), where a person to whom this Act applies who is charged with a child sexual assault offence appears before the Supreme Court or the District Court and:

(a) does not plead guilty to the charge; or
(b) refuses to give an undertaking to the court under section 23,

this Act shall cease to apply to the person in relation to that charge.

(2) Where a person appearing before the Supreme Court or the District Court as referred to in subsection (1) in relation to a charge does not plead guilty to that charge but, instead, pleads guilty before trial to another child sexual assault offence and the plea in respect of the other offence is accepted by the prosecution:

(a) this Act shall not cease to apply to the person by reason only of the person's failure to plead guilty to the original charge; and

(b) subject to any other provision of this Act, this Act shall continue to apply to the person in respect of the offence to which the plea of guilty was made as if that offence had been the offence originally charged.

PART 3—UNDERTAKING TO ATTEND PROGRAM, ETC.

Undertaking to attend the Program to be given to Court

23. Where a person to whom this Act applies who is charged with a child sexual assault offence appears before the Supreme Court or the District Court and pleads guilty before trial to the charge, the court shall request the person to give to the court an undertaking:

(a) to participate (or continue to participate) in the Program for such a period not exceeding, in total, 2 years, as the Director may require;

(b) during that participation and, where applicable, pending the commencement of that participation, to comply with all reasonable directions given by the Director to the person in relation to:

(i) the behaviour of the person (including access by the person to any other person or premises or place, whether or not the person has a legal or equitable interest in the premises or place);

(ii) any matter prescribed by the regulations; and

(iii) any other matter which the Director thinks necessary or appropriate in the circumstances; and

(c) to appear before the court in relation to the matter when required by the court to do so.
Procedure following giving of undertaking

24. If a person gives an undertaking at the request of a court under section 23, the court is (subject to sections 25 and 28) to proceed to conviction of the person for the offence concerned but is not to sentence or otherwise deal with the person in respect of the offence.

Person may be released from undertaking

25. (1) The court to which a person has given an undertaking under this Act may at any time, on the application of the person, release the person from that undertaking.

(2) Where a court releases a person from an undertaking given under this Act in respect of a child sexual assault offence, it may sentence or otherwise deal with the person for the offence as if the undertaking had not been given.

Breach of undertaking etc.

26. (1) A person who has given an undertaking under this Act shall, unless the person has been released from the undertaking, comply with the undertaking and the requirements made by or under this Act or the regulations.

(2) Where the court to which a person has given an undertaking under this Act is notified by the Director, or a person to whom the Director delegates the duty, of any failure by the person to comply with the undertaking or the requirements made by or under this Act or the regulations, the court shall determine whether the person concerned should appear before the court in relation to the matter.

Requirement to appear or issue of warrant on breach

27. If it appears to the court to which a person has given an undertaking under this Act that the person has failed to comply with the undertaking or the requirements made by or under this Act or the regulations, the court may require the person to appear before the court in accordance with the undertaking or may issue a warrant for the arrest of the person and directing that the person be brought before the court as soon as possible after arrest.
Powers of court on breach

28. Where the court to which a person has given an undertaking under this Act is satisfied that the person has failed to comply with the undertaking or the requirements made by or under this Act or the regulations and that the failure is not of such a minor nature that no action is warranted, the court may, whether or not the undertaking is current:

(a) sentence or otherwise deal with the person as if the undertaking had not been given; or

(b) direct that the undertaking to participate in the Program be extended for such further period, not exceeding 12 months, as the Director may require in addition to the original period for which the person was required to participate in the Program.

Court may be constituted by another judge

29. The powers, authorities, duties and functions which are required or permitted to be exercised or performed by the court to which a person has given an undertaking under this Act may be exercised or performed by that court, whether or not it is constituted by the same judge as that to whom the undertaking was given.

Person who has complied with undertaking not to be further prosecuted etc.

30. (1) Where a person who has given an undertaking under this Act in respect of a child sexual assault offence has complied with the undertaking and the requirements made by or under this Act or the regulations, no further proceedings shall be taken against the person in respect of the offence.

(2) For the purposes of subsection (1), a person who has given an undertaking under this Act in respect of a child sexual assault offence shall be regarded as having complied with the undertaking and the requirements made by or under this Act or the regulations at the expiration of the period (including any extension of the original period under section 28) for which the person was, in accordance with the undertaking, required to participate in the Program in relation to the offence unless, at the expiration of that period, any failure by the person has been notified to the court to which the undertaking was given but has not been determined.

(3) Where at the expiration of the period for which a person was required to participate in the Program a failure by the person has been notified to the court but has not been determined, the person shall be regarded as having complied with an undertaking given
under this Act if the court determines, in relation to that failure, that the person need not appear before the court or that no action is warranted.

PART 3A—PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM

The Program

30A. (1) The Pre-Trial Diversion of Offenders Program is a program for the treatment of a person who commits a child sexual assault offence with or upon the person’s child or the child of the person’s spouse or de facto partner.

(2) The Program is one which is approved for the time being by the Minister for Health after consultation with the Attorney General and the Minister for Community Services.

Administration of the Program

30B. (1) The Department of Health is to administer the Program.

(2) The Director-General of that Department is to prepare an annual report on the operation and effectiveness of the Program being administered by the Department and is to forward the report to the Attorney General, the Minister for Health and the Minister for Community Services.

PART 4—MISCELLANEOUS

31. * * * * *

Certain defects not to invalidate proceedings

32. A failure to comply with section 6 or 8 shall not invalidate any proceedings.

Evaluation of administration of Act

33. The Attorney General and the Minister for Health, in consultation with the Minister for Youth and Community Services, shall make arrangements for the administration of this Act to be monitored and for reports giving an evaluation of that administration to be given to those Ministers.
Regulations

34. (1) The Governor may make regulations, not inconsistent with this Act, for or with respect to any matter that by this Act is required or permitted to be prescribed or that is necessary or convenient to be prescribed for carrying out or giving effect to this Act and, in particular, for or with respect to:

(a) the undertakings to be given by persons in accordance with this Act;

(b) requirements to be complied with by persons who have given undertakings in accordance with this Act;

(c) the content and conduct of, and any other matter relating to, the Program;

(d) attendance at the Program by persons who have given undertakings under this Act; and

(e) the notification of a failure by a person to comply with any undertaking given under this Act or the requirements made by or under this Act or the regulations in relation to the person.

(2) A provision of a regulation may:

(a) apply generally or be limited in its application by reference to specified exceptions or factors;

(b) apply differently according to different factors of a specified kind; or

(c) authorise any matter or thing to be from time to time determined, applied or regulated by any specified person or body,

or may do any combination of those things.

Savings and transitional provisions

35. Schedule 1 has effect.

____________________________________
SCHEDULE 1—SAVINGS AND TRANSITIONAL PROVISIONS

(Sec. 35)

Application of amendments made by Pre-Trial Diversion of Offenders (Amendment) Act 1993

1. (1) Section 3A does not apply to proceedings pending at the commencement of that section if the person charged with the offence concerned was assessed under section 14 before that commencement.

(2) Section 24 (as substituted by the Pre-Trial Diversion of Offenders (Amendment) Act 1993) does not apply to proceedings pending at the commencement of Schedule 1 (10) to that Act in which the person charged with the offence concerned pleaded guilty or not guilty before that commencement.

_____________________________

NOTES

Table of Acts

Pre-Trial Diversion of Offenders Act 1985 No. 153. Assented to, 28.11.1985. Date of commencement, secs. 1 and 2 excepted, 28.5.1989, sec. 2 (2) and Gazette No. 62 of 19.5.1989, p. 2995. This Act has been amended as follows:


### Table of Amendments

Long title—Am. 1993 No. 7, Sch. 1 (1).

Sec. 2A—Ins. 1993 No. 7, Sch. 1 (2).

Sec. 3—Am. 1993 No. 7, Sch. 1 (3).

Sec. 3A—Ins. 1993 No. 7, Sch. 1 (4).

Sec. 4—Am. 1987 No. 58, Sch. 3.

Sec. 6—Am. 1993 No. 7, Sch. 1 (5).

Sec. 8—Am. 1986 No. 212, Sch. 1.

Sec. 9—Am. 1993 No. 7, Sch. 1 (6).

Sec. 10—Subst. 1993 No. 7, Sch. 1 (7).

Sec. 11—Am. 1993 No. 7, Sch. 1 (6) (8).

Secs. 12, 13—Am. 1993 No. 7, Sch. 1 (6).

Sec. 14—Subst. 1993 No. 7, Sch. 1 (9).

Secs. 15, 16—Am. 1993 No. 7, Sch. 1 (6).

Sec. 17—Am. 1993 No. 7, Sch. 1 (6) (10).

Sec. 19—Subst. 1995 No. 22, Sch. 2.

Sec. 20—Am. 1993 No. 7, Sch. 1 (6).


Sec. 23—Am. 1993 No. 7, Sch. 1 (6).


Sec. 25—Am. 1993 No. 7, Sch. 1 (13).

Sec. 26—Am. 1993 No. 7, Sch. 1 (14).

Sec. 28—Am. 1993 No. 7, Sch. 1 (6) (15).

Sec. 30—Am. 1993 No. 7, Sch. 1 (6).

Part 3A (secs. 30A, 30B)—Ins. 1993 No. 7, Sch. 1 (16).
Sec. 31—Rep. 1993 No. 7, Sch. 1 (17).
Sec. 34—Am. 1993 No. 7, Sch. 1 (6).
Sec. 35—Ins. 1993 No. 7, Sch. 1 (18).
Sch. 1—Ins. 1993 No. 7, Sch. 1 (19).
____________________________________
PRE-TRIAL DIVERSION OF OFFENDERS REGULATION 2000

under the

Pre-Trial Diversion of Offenders Act 1985

His Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Pre-Trial Diversion of Offenders Act 1985*.

JEFFREY SHAW, Q.C., M.L.C.,

Attorney General

EXPLANATORY NOTE

The object of this Regulation is to repeal and remake, without changes in the substance, the provisions of the *Pre-Trial Diversion of Offenders Regulation 1995*. The new Regulation deals with the following matters:

- the maximum periods for which proceedings to which the *Pre-Trial Diversion of Offenders Act 1985* applies may be adjourned for the purposes of the Act,
- the guidelines to be observed by a prosecutor in deciding whether a person should be referred for assessment as to the person’s suitability for participation in the Pre-Trial Diversion of Offenders Program conducted under that Act,
- matters relating to the carrying our of such an assessment,
- other formal matters.
Pre-Trial Diversion of Offenders Regulation 2000

Explanatory note

This Regulation is made under the *Pre-Trial Diversion of Offenders Act 1985*, including sections 9, 10, 13, 14, 17 and 34 (the general regulation-making power).

This Regulation is made in connection with the staged repeal of statutory rules under Part 3 of the *Subordinate Legislation Act 1989*.

This Regulation comprises or relates to matters of a machinery nature.
Pre-Trial Diversion of Offenders Regulation 2000

Contents

<table>
<thead>
<tr>
<th>Item</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Regulation</td>
<td>4</td>
</tr>
<tr>
<td>Commencement</td>
<td>4</td>
</tr>
<tr>
<td>Definitions</td>
<td>4</td>
</tr>
<tr>
<td>Maximum adjournment periods sections 9, 13 and 17</td>
<td>4</td>
</tr>
<tr>
<td>Prosecutor’s guidelines: section 10</td>
<td>5</td>
</tr>
<tr>
<td>Assessment procedure: section 14</td>
<td>5</td>
</tr>
<tr>
<td>Repeal</td>
<td>6</td>
</tr>
</tbody>
</table>
Clause 1 Pre-Trial Diversion of Offenders Regulation 2000

Pre-Trial Diversion of Offenders Regulation 2000

Name of Regulation.

This Regulation is the Pre-Trial Diversion of Offenders Regulation 2000.

2. Commencement

This Regulation commences on 1 August 2000.

3. Definitions

(1) In this Regulation:

Director means the person nominated by the Director-General of the Department of Health to be the Director of the Program.

Program means the Pre-Trial Diversion of Offenders Program approved in accordance with Part 3A of the Act.

the Act means the Pre-Trial Diversion of Offenders Act 1985.

The explanatory note and table of contents do not form part of this Regulation.

4. Maximum adjournment periods: sections 9, 13 and 17

For the purposes of section 9 of the Act, 4 weeks is prescribed as the maximum period for which proceedings may be adjourned to allow a determination to be made as to whether a person is to be referred for assessment for suitability for participation in the Program.

(2) For the purposes of section 13 of the Act, 8 weeks is prescribed as the maximum period for which proceedings may be adjourned to allow such an assessment to be made.

(3) For the purposes of section 17 of the Act, 2 weeks is prescribed as the maximum period for which proceedings may be adjourned to allow the person charged to be given advice and information.

Prosecutor’s guidelines: section 10

For the purposes of section 10 of the Act, the following guidelines are prescribed for consideration by the prosecutor in determining whether a person is to be referred for assessment:
**GUIDELINES**

A prosecutor should not refer a person for assessment:

if the child sexual assault offence with which the person is charged is alleged to have been accompanied by acts of violence towards the alleged victim or others; or

if the person is under 18 years of age; or

if the person has a prior conviction for a sexual offence, whether in New South Wales or elsewhere; or

if the alleged victim is 18 years of age or more when the person first appears before a Justice in relation to the offence; or

if the person has previously been requested under section 23 of the Act to give an undertaking in relation to any offence.

A prosecutor may take into account any other matter that the prosecutor considers relevant to the question of whether or not the person should be referred for assessment.

**Assessment procedure: section 14**

(1) Within one week after the prosecutor’s decision to refer a person for an assessment of suitability for participation in the Program, the prosecutor must notify the Director in writing of that decision.

(2) Within one week after the assessment is carried out, the Director must notify the prosecutor of the results of the assessment and (if appropriate) the reasons why the person concerned is not suitable for participation in the Program.

(3) The assessment must be carried out by means of structured clinical interviews of:

(a) the person referred for assessment; and such other persons acquainted with the person referred for assessment as the Director may determine.

**Repeal**

The Pre-Trial Diversion of Offenders Regulation is repealed.

Any act, matter or thing that, immediately before the repeal of the Pre-Trial Diversion of Offenders Regulation 1995, had effect under that Regulation continues to have effect under this Regulation.
Appendix C: Sample Treatment Agreement

NSW PRE-TRIAL DIVERSION OF OFFENDERS PROGRAM

TREATMENT AGREEMENT

I ........................................ WILL ABIDE BY THE FOLLOWING CONDITIONS OF THE NSW PRE-TRIAL
DIVERSION OF OFFENDERS (CHILD SEXUAL ASSAULT) PROGRAM (hereinafter called ‘THE PROGRAM’)
FOR A MINIMUM PERIOD OF TWO (2) YEARS FROM

(Date)

1. I will move out of the residence/s where my children/stepchildren
   _______________ reside and remain out until or if the Director of the Program
   approves a family reunification plan.

2. I will notify the Director of my place of residence. I understand that the Director
   must approve my living arrangements. I will seek approval for any change of
   accommodation and understand I require approval before committing myself to
   the proposed change of accommodation. I will accept visits to my place of
   residence by the Director or person/s nominated by the Director.

3. I will not reside or enter within a ............ kilometre radius of the residence of my
   partner/ex-partner _______________ without the prior written permission of the
   Director.

4. I will not reside where there are children under the age of sixteen (16) years.

5. I will not visit the residence/s of the children named above without the prior written permission of
   the Director.
6. I will not have contact with the children named above without the prior written permission of the Director. I understand that contact includes telephone calls, mail and messages via third parties.

7. I will not act violently towards, threaten, harass or otherwise verbally abuse the children named above, my partner/ex-partner ________________ or Program staff.

8. I will inform the Director of any new relationships I am forming in the nature of a de facto relationship, marriage or cohabitation.

9. I will seek and maintain employment (paid or unpaid) which is approved by the Director. I understand the Director may require me to disclose my participation in the Program to my employer. I also understand any proposed change of employment must have prior approval of the Director.

10. I will punctually attend all scheduled therapy sessions (group, individual and family sessions). I will not be under the influence of any illegal drugs or alcohol when attending therapy sessions.

11. I will negotiate medical services to be provided by a General Medical Practitioner and will provide consent for exchange of information between the Program and the General Medical Practitioner.

12. I understand that if I commit a further sexual offence while participating in the Program I will be suspended from the Program and will appear before Court for this as a Breach of Treatment Agreement. I also understand that this is separate to any further criminal prosecution which may be commenced in relation to the further sexual offence.

13. I will notify the Director of the details of any breaches of the law I commit including details of traffic offences, criminal charges, domestic violence orders.

14. I understand my participation in the Program is upon a basis of limited confidentiality. Information regarding my progress in treatment and opinion formed by the Program regarding any future or continuing risk I pose to others may be conveyed to those affected.

15. I consent to the Program making available to my partner/ex-partner __________ my Treatment Agreement, reviews of progress and significant work completed by myself in relation to my therapy.
16. I acknowledge that I understand the responsibility the Program has to report actual or suspected abuse by myself to relevant authorities, typically being the Department of Community Services and NSW Police Force.

17. I will hold in confidence:

   i. The names of other persons and their families in the Program.

   ii. The content of all group therapy sessions as it relates to other persons and their families in the Program.

   iii. As an exception, I will notify treatment staff of any information concerning another Program participant being a danger to themselves or others, or any suspected child abuse, including knowledge of any other Program participant breaching their Treatment Agreement.

18. I authorise the Director to seek relevant information from other agencies which have been involved in the treatment of myself.

19. I will abide by any reasonable conditions or directions for the duration of my participation in the Program.

20. I understand that unsatisfactory participation and progress in the Program, as assessed by the Director, will result in my suspension from the Program and to appear before Court.

21. I understand that failure to comply with these conditions may result in my suspension from the Program. I understand that the Department of Community Services and the Director of Public Prosecutions will be notified of breaches of this Agreement.

22. I will not have contact with children under the age of sixteen (16) years except as occurs incidental to my day-to-day life, for example, at places such as shops, banks, public transport.

23. I will not have contact with other Program participants or people who have sexually assaulted children, except during group therapy sessions. Contact that is not allowed includes; exchanging telephone numbers/addresses, meeting before or after group therapy, comparing or swapping therapy notes, employing or working with other program participants or people who have sexually assaulted children.
24. I understand that I am responsible for clarifying any aspect of my participation in treatment of which I am unclear.

25. I understand that the Director may delegate decision making regarding my participation to other Program staff, most usually being the Clinical Coordinator.

**Other Conditions:**

**SIGNED:**

________________________ ____________  __________________________  ____________
PROGRAM PARTICIPANT  DATE

________________________ ____________  __________________________  ____________
PROGRAM DIRECTOR  DATE

________________________ ____________  __________________________  ____________
WITNESS  DATE
Appendix D: Orientation Information for Program Participants who have Sexually Abused Children

Cedar Cottage
New South Wales Pre-Trial Diversion of Offenders Program

28 Railway Parade
Westmead NSW 2145
Tel: (02) 9891-6199
Fax: (02) 9891-1080
email: cedar_cottage@swahs.health.nsw.gov.au

Postal Address:
PO Box 45
Westmead NSW 2145

ORIENTATION INFORMATION
FOR PROGRAM

PARTICIPANTS WHO HAVE
SEXUALLY ABUSED CHILDREN

FEBRUARY 2007

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A NSW Health Department Service
# TABLE OF CONTENTS

1. GENERAL INTRODUCTION ...........................................1

2. TREATMENT AGREEMENT 1 ...........................................1
   (i) General ........................................................................1
   (ii) Living Arrangements & Contact with Family Members .......2
   (iii) Family Reunification ..................................................4
   (iv) Attendance ..................................................................4
   (v) Confidentiality ...........................................................5
   (vi) Compliance with Conditions of Treatment Agreement ....6
   (vii) Association with Other Program Participants ..........6
   (viii) Employment .............................................................6
   (ix) Medical Services .........................................................7
   (x) Drug Screening ..........................................................7
   (xi) Telephone ..................................................................8
   (xii) Contacting Cedar Cottage outside business hours .....8

3. FURTHER DISCLOSURES ...............................................8

4. UNDERTAKING ...................................................................9

5. BREACH OF UNDERTAKING ...........................................9

6. THERAPY ......................................................................10
   (i) Allocation of Therapist ................................................10
   (ii) Individual ..................................................................10
   (iii) Group ......................................................................10
   (iv) Workbooks ...............................................................10
   (v) Reviews/Extension of Treatment ..................................11
   (vi) Audience ..................................................................11
   (vii) Maintenance and Support System (MASS) .................12
   (viii) Video Recording of Therapy Sessions .......................12
   (ix) Photocopying of Work Submitted ...............................14
   (x) Submitting Work ........................................................14
   (xi) Purchase of Materials ...............................................14

7. VICTIMS COMPENSATION ...........................................15

8. COMMITMENT TO YOUR PROGRAM ..............................15

9. POST COMPLETION / IN RECOVERY ..............................15

10. COMPLAINTS ................................................................16

TIMELINE FOR THERAPY .................................................17
    Assessment ..................................................................18
    Four Months ..................................................................19
    Eight Months ...............................................................20
    12 Months ..................................................................21
    16 Months .................................................................22
    20 Months ..................................................................23
    Two Years ..................................................................24
# TABLE OF CONTENTS

(Continued)

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX 1</td>
<td>(Sample Undertaking)</td>
<td>25</td>
</tr>
<tr>
<td>APPENDIX 2</td>
<td>(Reviewing Your Progress)</td>
<td>26</td>
</tr>
<tr>
<td>APPENDIX 3</td>
<td>(Crime Description)</td>
<td>27</td>
</tr>
<tr>
<td>APPENDIX 4</td>
<td>(Goals, Standards, Plan of Action)</td>
<td>29</td>
</tr>
</tbody>
</table>
1. **GENERAL INTRODUCTION**

The Pre-Trial Diversion Program (Cedar Cottage) is run by the NSW Department of Health and administered through Sydney West Area Health Service. While a number of government departments contribute to policies of the Program, the Pre-Trial Diversion Program is a NSW Health initiative.

The general conditions of the treatment program are set out in the Program brochure that you should have received prior to your assessment at Cedar Cottage. The matters addressed in this information booklet further explain aspects of the Program. Most of these are addressed during your assessment.

The most important thing to understand about your treatment program at Cedar Cottage is that it is designed as your own individual program. That is, while there may be similarities and parallels between your program and those of other participants, it is not the same. In addition, the design of your treatment program relies heavily upon you setting the appropriate goals and standards. The formal requirements of the treatment program should be consistent with the goals and standards you have set and therefore be supported by yourself. The conditions set out in your Treatment Agreement apply to yourself and are not requirements with respect to other family members. The participation of other family members is upon a different basis from your participation in this Program.

2. **TREATMENT AGREEMENT**

(i) **General**

a. Your Treatment Agreement sets out the conditions which you support as being important and necessary for you to participate in treatment at Cedar Cottage. It is a formal agreement which is the basis of any Undertaking you will make to the District or Supreme Court to comply with the reasonable directions of the Director for the period in which you attend Cedar Cottage. Please re-read your Treatment Agreement before reading these guidelines.

b. **Variations to Treatment Agreement:** Temporary or permanent variations to the Treatment Agreement need to be arranged by formally requesting the variation to the Director of the Program in writing. Before applying for a variation, you should consider the relevant issues associated with the change and discuss in individual therapy what you have taken into account.

Unless there are exceptional circumstances, you should allow **at least two weeks** for the Director to make a decision on your application for a variation.

c. You cannot act outside the conditions in your Treatment Agreement until your formal written request has been answered by the Director giving permission for you to do so.

d. **Non-Abusive Lifestyle:** Your lifestyle has to be such that you are not in the vicinity of your victim(s), or in any way intrude upon their lives (e.g. being near any place your victim(s) are likely to be). Your lifestyle should be
consistent with the principles of personal responsibility and non-abusive practices. In particular, matters which are not allowed are those associated with sexually abusive conduct (such as use of/possession of/access to pornography, viewing sexually explicit or violent films or use of the Internet to access such material, paying for sex or use of illegal drugs). Not intruding upon victim/s includes you not being near any place where your victim/s are likely to be (as well as not living in the same place).

e. The condition of 'no contact with children under the age of 16' means that you should not be present in premises or businesses likely to be frequented by children or families with children.

(ii) Living Arrangements and Contact with Family Members.

a. You must move out of the family home and remain out until the Director of the treatment program approves otherwise. You cannot go near the home for any reason without the written permission of the Director.

b. You cannot live within a 10 km radius of your family home or place where your child/children live. If you are from a non-metropolitan area, you cannot live in the same town.

c. You must take all necessary steps to avoid "unplanned" contact with your child/children. This includes changing your doctor, dentist, usual shopping centre etc.

d. You may not live with your parent/s as this inhibits relationships for them as grandparents. If at the time of referral you are staying with your parents, you will be given reasonable time to move.

e. You may not live or stay overnight in a residence where there is any child under the age of 16 years.

f. You cannot visit or have any other contact with any of the children in the family without the written permission of the Director. If any of the named children turn 18, this does not mean you can begin having contact (for this reason). Contact includes such things as:
   • Driving by the house.
   • Talking through other people (e.g. "tell the kids I said hello").
   • Sending letters or cards.
   • Giving presents.
   • Talking on the phone or leaving messages.
   • Waving from a distance.
   • Attending the same church service.
   • 'Accidentally' speaking with a child when ringing to speak with your partner/ex-partner.
   • Sending e-mails to any member of the household where your victim/s live.

This is not a complete list. Direct and indirect contact is not allowed. If you are in any doubt, do not act without contacting your therapist.
g. **Photographs:** You are not permitted to have photographs of your children at the beginning of treatment. This is to ensure you maintain an appropriate boundary with your family and to allow a more thorough review of your children's needs and of your relationship with them. Requests for photographs or knowing that Program participants have photographs can also be traumatic for family members. Should you reach a point when it would be appropriate for you to have photographs of your children, you should discuss this with your therapist.

h. **Contact with Spouse or Partner:** There is generally no restriction on contact with your partner, provided your partner wants this. You must keep your therapist informed of any contact you have with your partner/ex-partner.

i. **Where You May Live:** Your living arrangements have to be approved by the Director. You will need consent to visit your family's place of residence if the Director advises this may occur (refer to your Treatment Agreement). Living with, or in close proximity to, children will not be approved and excludes certain types of accommodation such as caravan parks, accommodation near schools or places for the care of children or where children frequent. You should advise the Director of any possibility of you using the same shopping centres, streets or any other places which may result in your having contact with children named in your Treatment Agreement.

j. **Living arrangements** includes arrangements for wherever you live or stay overnight. Therefore, even if you are not going to stay away from your home overnight, you will need to apply for a variation and have this approved. You may propose an ongoing situation, perhaps for work reasons, to stay regularly in more than one place. You will need to have each place approved and maintain a record for purposes of accountability. You must keep the Program informed of all proposed changes in living arrangements, address, phone, employment status and so on. You must seek approval from the Director regarding any such proposed changes.

k. **Unauthorised Contact with Children:** Should any unauthorised contact between yourself and your children occur, you must inform your therapist immediately.

**(ii) Family Reunification.**

a. Family reunification is not a goal of the Program.

b. If you wish to reunite with your family, this should be identified by yourself as an issue for treatment. All steps towards reunification should take place as part of your treatment program. You will need to develop a reunification plan and apply for each step as variations of your Treatment Agreement. We will not accept or participate in a reunification plan if it is not what everybody in your family wants.

Cedar Cottage will advise the Department of Community Services of any plans on your part to re-establish contact with your children.
(iv) **Attendance**

**Minimum Attendance**

**First 2 Months**
- Weekly individual therapy
- Fortnightly group therapy, then

**After 2 Months**
- Fortnightly individual therapy
- Alternate fortnightly group therapy

**Except June & November**
- Weekly workshops (and weekly individual therapy if within first 2 months of therapy)

**Every 4 months**
- Review of progress meeting

In addition to this schedule, further individual or other sessions may be arranged if required.

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a. You are required to attend scheduled individual, group and family therapy sessions punctually.

b. Absence from a session will only be excused in advance, by calling your therapist. An absence will be excused only for serious illness or family emergencies and requires documentation (e.g. medical certificate). Absence not excused in advance should be discussed with your therapist as soon as possible. You must confirm absence by writing to the Director enclosing a medical certificate. Medical certificates must be obtained on the day of illness. You must forward the medical certificate to Cedar Cottage immediately or hand deliver it within 24 hours.

c. Requirement to attend does not apply to your spouse or children.

d. When you attend Cedar Cottage you must be appropriately dressed and behave respectfully towards all staff and other clients. Appropriately dressed means that you keep a high standard of personal hygiene, if you wear shorts they must be dress shorts, you may not attend wearing thongs or barefoot. You may take a drink with you into sessions but eating in sessions is not permitted. This includes chewing gum and snack food.

You need to describe clearly your thoughts in your logs/journal and other writings. If this includes reference to foul or indecent language you should use inverted commas. It is inappropriate for you to use this language in general conversation during your therapy sessions.
e. You are required to be sober when you attend Cedar Cottage. If problems with alcohol or other drugs are identified, your Treatment Agreement may be amended with special conditions.

You may be subject to random alcohol or drug screening at Cedar Cottage. Alcohol testing is conducted on-site and drug screening is conducted by arrangement with your General Medical Practitioner (see ‘Drug Screening’ on page 6).

(v) Confidentiality

a. Confidentiality (i.e. keeping private information which is entrusted to you) is an important issue at Cedar Cottage. Confidentiality is different to secrecy. Secrecy involves keeping information from others who have a legitimate interest in, or right to that information.

The staff at Cedar Cottage share information with each other, but not with anyone else unless you have agreed. The exceptions to this are:

- A breach of the conditions of the Treatment Agreement,
- Information concerning child abuse, and
- Information concerning criminal activity.

b. You are expected to keep confidential any information you hear in group therapy sessions which identifies participants.

However, you should notify treatment staff of any information concerning a client being a danger to themselves or others, or any suspected child abuse including knowledge of any other Program participant breaching their Treatment Agreement.

(vi) Compliance with Conditions of Treatment Agreement

a. Failure to comply with conditions of the Treatment Agreement is a breach of your Undertaking to the District Court.

b. A standard section of the Treatment Agreement for Program participants at Cedar Cottage is that which permits visits to your home by person(s) nominated by the Director. This is one aspect of ensuring the conditions you undertake are upheld.

c. Investigation/surveillance personnel are used when necessary to provide further information regarding compliance. You will be required to provide passport-type photographs of yourself and details of your physical appearance for this. A separate letter will be sent to you regarding this.

d. You also need to provide us with details of your place of employment, nature of employment, place of residence and details of your vehicle. This information will be reviewed at each review of progress.
(vii) **Association with Other Program Participants**

Participation in group therapy will bring you into contact with other Program participants. This contact is limited to the group therapy sessions and any other contact with group members is not permitted. This contact includes:

- Swapping phone numbers/addresses.
- Meeting before or after the group.
- Comparing therapy notes (outside group).
- Moving in together.
- Going on holidays together.
- Employing or working with each other
- Travelling home together after therapy. *

If you have any doubts about this, raise them with your therapist or the Director.

(viii) **Employment.**

Apart from needing details of the place of your employment as mentioned above, you will need to seek approval for employment (paid or unpaid). Depending upon the nature of your employment you may need to disclose to your employer your participation in this Program. The approval of employment focuses around the issue of safety for children and avoidance of situations which may be risky for you. Assessment of these factors will determine the level of disclosure which may be necessary for your employer.

(ix) **Medical Services.**

You will need to negotiate a specific service to be provided to you by a General Medical Practitioner who is not the same person or in the same practice as your family GP. The Program will need your permission to speak with your GP and soon after commencing in the Program you will be required to have a full review of your health status. This is not an assessment activity but rather a required step early in your participation in the Program. It may point towards matters which need to be addressed focussing on your general health or lifestyle.

(X) **Drug Screening**

If you have a drug problem identified, you may be required to participate in random drug testing. This will be arranged in the following way:

a. Once a drug use problem is identified, the Director will meet with you and your therapist. A plan will be put together in which your responsibility to manage this problem is clearly set out. Also set out will be the action Cedar Cottage will take. You will be responsible for remaining drug-free and participating in specialist treatment if required. These matters and acknowledgement of random drug screening will be included in your Treatment Agreement.

* Many clients of Cedar Cottage travel by train. You may travel by the same train, but must not travel together, i.e. sit together or talk with each other.

February 2007

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b. Random drug screening may be required at any time thereafter. To establish this procedure you will need to:

- have a GP (as described above in 'Medical Services'). The arrangement for random drug screening is in addition to general medical services.
- provide signed consent for exchange of information regarding this procedure.
- take a letter from Cedar Cottage to your GP which outlines the requirements of this procedure. If your GP does not agree to providing this service, you will need to find another GP who does agree. The GP will be asked to supervise you producing a urine sample, package it and send it to a testing laboratory. Cedar Cottage provides you with the testing kit, including postage paid wrapping. The consultation fee for this service by the GP will be your cost. At the time you are directed to undertake random drug screening, you will be told when you must go to your GP. This may be within a number of hours (generally less than 24 hours) and may be a direction for you to immediately attend your GP’s surgery to provide a sample for testing.

c. When Cedar Cottage receives the results of your testing, you will be provided with a copy by us, as will your GP.

(i) Telephone.

You are required to have a landline (not mobile) telephone at your place of residence on which we can contact you if necessary. A mobile phone is not required and is not an alternative to this requirement.

(ii) Contacting Cedar Cottage outside business hours:

Cedar Cottage’s business hours are 8.30am to 5pm Monday to Friday. An answering machine is in operation outside those hours. If you leave a message, your call will be returned the next business day.

3. FURTHER DISCLOSURES.

It is common for men participating in the Program to disclose further sexual offending which they committed prior to commencing in treatment. There are a number of matters which you should bear in mind in this regard.

- The Program regards further disclosures by men in the Program as being a sign of positive commitment to change.
- The Program will act on further disclosures to ensure the safety and well-being of children or adults who have been abused. This will mean disclosure to the Department of Community Services in relation to people who are currently children, and to the NSW Police if the person abused is currently an adult and the matter disclosed is defined by the NSW Crimes Act as a “serious offence”. (This includes virtually all sexual offences).

February 2007

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If a further disclosure leads to further or new prosecution, it will not mean that you are excluded from the Program if you committed these offences prior to your assessment. Once you have entered your Undertaking (see below), it cannot be varied to include other offences, even if they are against the same child or children. This means that further disclosure of sexual offending which took place prior to you beginning the Program and which is disclosed after entering your Undertaking cannot be considered under the NSW Pre-Trial Diversion of Offenders Act. You are therefore strongly encouraged to advise of any additional matters incurred prior to entering your Undertaking to avoid later difficulties.

There have been a number of man later prosecuted for offences committed prior to commencing the Program whilst participating in the Program. At sentencing, the court has implemented a range of outcomes in these situations.

4. **UNDERTAKING.**

Your Undertaking is a formal agreement you make with the District Court. (Ref: 2(i)(a) and 2(v)(a) above). Your Undertaking is drafted by your solicitor per s.23 of the NSW Pre-Trial Diversion of Offenders Act.

You must notify the Program when you are due to go to Court to enter your Undertaking so we can provide a copy of your Treatment Agreement and a progress report to the Court.

You must also provide us with a copy of your Undertaking, the name of the Judge to whom you gave the Undertaking and the court in which you appeared.

**Appendix 1** is a sample of an Undertaking document. Some solicitors vary the form but it must comply with Section 23 of the NSW Pre-Trial Diversion of Offenders Act.

5. **BREACH OF UNDERTAKING.**

The Director is required to report to the Court any breach of Undertaking. The Court then considers the matter and determines the appropriate outcome.

If you breach your Undertaking at any time, you should immediately advise the Director in writing and begin taking appropriate steps. Concealing any breach will only serve to compound difficulties for yourself (and perhaps others).

The Court has the power to deal with breaches in several ways. If the Court decides that the reported breach is important enough for the person to be brought before the Court, the next issue is to decide whether a breach has been committed. If this is proven the Court can:

- Exclude the person from the Program and sentence them for the offences for which they were convicted at the time of entering the Undertaking; or
- Return the person to the Program, extending the period of the Undertaking by up to 12 months.
6. **THERAPY.**

**Allocation of therapist.**

You will be allocated an individual therapist, and also a group therapist(s). The allocation of your individual therapist may be for the period of your treatment, or you may be re-allocated a different therapist at some stage in your treatment. This will be done after discussion with you.

**Individual/Small Group therapy**

Your individual therapy may be replaced by small group therapy at some stages of your participation. Small group consists of two or three Program participants with a therapist covering the same material as in individual therapy.

At the beginning of therapy you should discuss with your therapist how you will use therapy to progress towards your goals. Therapy will involve you undertaking a range of tasks. It is important that before taking any significant steps, such as facing up to your partner about a new aspect of the abuse, you review in therapy your plan for taking that step. You should also evaluate in therapy each step you take.

Individual therapy will be scheduled no less frequently than once per fortnight. Your therapist may schedule therapy more frequently at different times. You also may request more frequent therapy or special purpose sessions for particular issues you are working on.

**Group.**

At the commencement of your therapy you will be allocated to a group for therapy, in addition to your individual therapy. You will attend group fortnightly throughout the period of your participation.

You will also attend a series of weekly workshops in June and November each year.

**Workbooks.**

A significant element of your treatment will be relapse prevention work. This requires the purchase of a workbook entitled ‘Who Am I and Why Am I in Treatment’ at a cost of $28 (this can be paid in instalments). Relapse prevention work leads to you establishing your Maintenance and Support System (MASS).

In addition, within the first six months of your treatment, you will need to purchase another workbook entitled ‘Maintaining Change’ at a cost of $20. This workbook is an authorised photocopy.

**Reviews/Extension of Treatment**

a) Formal review of your progress in treatment will be conducted at regular intervals by the Director or Clinical Co-ordinator and your therapist.
The reviews are scheduled at 4, 8, 12, 16, 20 and 24 months from the time you commence treatment by signing the Treatment Agreement. An informal review is conducted by your individual therapist with yourself at two (2) months.

b) Other formal reviews will be conducted if the Director believes this to be necessary.

c) At the formal reviews you will be given a written evaluation of your progress by your individual and group therapists. You will need to bring your evaluation of yourself in treatment so far.

d) An element considered in all reviews is your developing skill in self-evaluation. If you have difficulty with evaluating your own progress this will be reflected in the formal review. Some general guidelines for preparing your own evaluation of progress are given in Appendix 2.

e) Depending on your partner/ex-partner's wishes, you may be expected to convey the content of your review, your assessment of yourself and your stand regarding your therapists' review, to your partner/ex-partner. This is usually at a meeting at Cedar Cottage. You should discuss your plans for this at each review with your therapist. If your partner/ex-partner does not want to meet at Cedar Cottage, there is no requirement for them to do so. However, they are entitled to details of your progress at the time of the reviews or in the future.

f) Extensions of time are not automatically available to persons who fail to complete treatment within two years. Failure to complete in time is a breach of the Treatment Agreement requiring a Judge at the District Court to consider if an extension should be granted. A recommendation for your treatment to be extended will be provided only in circumstances where you establish it is warranted. This issue is considered at the 16 month review (or earlier). Your 20 month review will identify clearly if you are likely to complete in time or whether an extension is warranted.

**Audience.**

Your abusive actions involved secrecy and avoidance of responsibility. Making yourself accountable to significant people in your life is a central component of your treatment. In the course of your assessment and therapy you will need to identify people who are aware of your history and of your participation in treatment and who are well-placed to evaluate the changes you are making in yourself. That is what we mean by 'audience'.

**Maintenance and Support System (MASS).**

Our work with men who have sexually abused children indicates they need to remain alert to the risk of re-offending and of returning to abusive and disrespectful ways of relating to others. This requires the men to continue monitoring their thoughts, feelings and actions for the rest of their lives.
When you complete your relapse prevention work, you will be required to develop your Maintenance and Support System (MASS). Your MASS involves having at least 5 people who are aware of your abusive actions, and of your participation in the Pre-Trial Diversion Program. These persons must be fully informed of your relapse prevention plan including your risk factors. They need to be persons to whom you make yourself accountable and to whom you can turn to for support, and with whom you maintain regular contact.

MASS members are not responsible for your actions, nor are they responsible for whether or not you re-offend. However, MASS members must be committed to take action if you show signs of lapsing into abuse or abuse-related behaviours.

You should not begin putting together your MASS until agreement is reached with your therapist that you are ready. Cedar Cottage will assist your MASS members to become familiar with their role.

Video Recording of Therapy Sessions.

At the beginning of your assessment you gave written permission for the video recording of your assessment sessions and, if accepted into the Program, of your therapy sessions. At Cedar Cottage we have clear guidelines regarding:

- Safekeeping of tapes,
- Court privilege,
- Length of time tapes are kept,
- Who can view tapes.

a. Safekeeping of Tapes:
The same level of confidentiality and safekeeping applying to your file applies to the recordings of your therapy sessions. Tapes are kept in secure storage and only Program staff have access to them.

b. Court Privilege:
The tapes of your treatment sessions are not privileged in Court. This means, same as with your file, that a Court may subpoena the tapes or require transcripts of the recorded sessions in legal proceedings.

c. Length of time the tapes are kept:
If you are found unsuitable for participation in the Pre-Trial Diversion Program, the tapes of your assessment will be erased after the Office of the Director of Public Prosecutions has been informed of your unsuitability. If you are accepted into the Program, the tapes may be kept until you meet the legal requirements for completion of treatment, after which time they will be erased. If you elect to continue therapy on a voluntary basis, the tapes may be kept for the period of your therapy contact and erased once you terminate contact with the Program. This is the maximum time limit. Therapists can make their own decisions regarding erasing tapes at an earlier date. Your consent is **not** required to erase tapes before the end of your treatment. If you are excluded from the Program, (that means that you are excluded from the Program by a Court decision) the tapes will be erased at that time. At times the Program may want to preserve some tapes for a longer period of time after you have ceased participating in the Program.
In this case, you will be asked whether you consent to the tapes being kept for a longer period of time. You will also be given reasons why the Program wants to keep these tapes.

d. Who can view the tapes?
You can. You will need to advise your individual or group therapist that you wish to view a particular tape. You will also need to make an appointment to view the tape at Cedar Cottage (available times to view video tapes are Monday to Friday 9am to 1pm and 2pm to 5pm [not available 1pm–2pm]). Tapes may not be taken out of Cedar Cottage. Viewing recorded sessions of your individual or group therapy and of face-up meetings may assist you in your self-evaluation. It is important that you discuss with your individual therapist how you are utilising the viewing of the tapes and that you have clear standards for this.

Family members or other relevant people in your audience may have reasons to view recordings of your treatment and of the face-ups you have done. On each occasion, your therapist will advise you of the request and your verbal consent is required for the viewing to proceed.

When face-up meetings are taped, the tape is available to all those present. In the case of your face-up to the siblings of the child/ren you abused, the tape is available to the child victim/s.

Without your consent, only the Program staff have access to the recordings of your therapy sessions. There may be special circumstances when professionals outside Cedar Cottage are interested in having access to recordings of treatment sessions (e.g., in the case of a research project). In such cases, you will be advised and your consent will be required for the tapes to be made available.

Photocopying of Work Submitted.

It is your responsibility to retain a copy of all work you submit to Cedar Cottage. Photocopying is the easiest option. For many this is impractical or too expensive. A cheaper alternative is to use carbon paper.

Some Program participants have requested to photocopy their work at Cedar Cottage. This is possible on occasions when you are unable to arrange a suitable alternative. The conditions for photocopying at Cedar Cottage are:

a. You must arrange a time prior to the appointment or time at which you plan to submit your written work, for you to be at Cedar Cottage and ensure a staff member is available to do the photocopying for you.

b. As photocopying is a 'service, GST is payable. The minimum fee is $1.10 per 5 (five) pages photocopied - to be paid at the time of copying. A receipt will be issued to you.

c. On any occasion when you request photocopying here, you need to have the correct money with you.

Therefore, while photocopying is available at Cedar Cottage, it should be used sparingly.
Submitting Work

You must submit your work by post or hand. Work may not be submitted by fax or email, unless specifically requested by your therapist.

All visits to Cedar Cottage during working hours (8.30am to 5pm Monday to Friday) need to be by appointment. This is because we also provide direct services to many children and partners or former partners of men in the Program. For this reason, if you wish to hand deliver any correspondence or treatment work, you will need to ring to confirm a suitable time.

Weekdays before 7.30am and after 8.30pm, and on weekends, you can deliver mail by hand to the locked mail box located immediately inside the Entrance B gate at Cedar Cottage. This mail box is cleared daily on weekdays, however, if you deliver mail to this mail box, please telephone Cedar Cottage and leave a message letting us know.

Purchase of Materials.

Sex log sheets may be purchased at $1.10 (GST incl.) per 5 sheets.

7. VICTIMS COMPENSATION

In New South Wales there is a Victims Compensation Scheme. Any person who has suffered harm as a result of criminal actions is entitled to claim compensation. This means it is likely that the child/children you have abused may be eligible to claim compensation. Victims Compensation is also available for "secondary victims". Most usually in your circumstances this would mean your spouse. Information about the Victims Compensation Scheme will be made available to your partner and the child/children who have been abused. The scheme is administered by a Tribunal, headed by a Magistrate. If compensation is awarded, the Tribunal is likely to seek contribution from yourself. The Tribunal will not make an award if it determines you will directly or indirectly benefit.

If you know that your victims are making, or intend to make, a claim for compensation, you should raise this matter with your therapist. You need to make clear how you are dealing with this situation. This means you need to be accountable for your internal processes (your thoughts and feelings), as well as your actions in relation to this matter.

8. COMMITMENT TO YOUR TREATMENT PROGRAM

The staff at Cedar Cottage will maintain an active commitment to your treatment program. This will mean encouragement, support and detailed review with you of your progress in the program.

Where you have made a stand for taking full responsibility for your actions, your therapists and other staff will not accept or promote ideas which imply or state anything less than this. For example, if you have previously lived a lifestyle whereby you have encouraged others to accept or make excuses for you, the staff at Cedar Cottage will not accept or make excuses for you.
Your commitment to your own treatment program will be met by the commitment of the staff.

9. POST COMPLETION / IN RECOVERY

Ongoing/maintenance therapy is available 'post-completion' – that is, after you have satisfactorily completed the terms of your Undertaking to attend for treatment. In many ways it is this post-completion phase which will be most crucial for you to demonstrate an ongoing commitment to a responsible and non-abusive life. Our experience has shown us that continuing with therapy can be of great benefit for the men concerned and their families.

Both individual and group therapy (In Recovery’ group meets once a month) are available to you after you meet the requirements of your court-supervised treatment. Please discuss your ‘post-completion’ plans with your therapist.

10. COMPLAINTS.

If for any reason you are unhappy with services provided to you at Cedar Cottage and wish to complain or pursue the matter in any other way, those concerns can be directed to the Program Director. You can do this by telephone, by arranging an interview or by letter. Any matters raised will be fully considered. Every effort will be made to resolve any issues identified.

If you do not feel comfortable approaching the Program Director, you may contact the Chief Executive Officer of Sydney West Area Health Service.

*If you are not clear about any aspect of your treatment – ask.*
TIMELINE FOR THERAPY

INFORMATION FOR PROGRAM PARTICIPANTS

The following pages are set out as a timeline for therapy. It is a guide that is used by therapists at Cedar Cottage for planning treatment for each individual person who has sexually abused a child or children. It is used as a guide and the order in which issues are addressed may vary from one person to another.

Many of the points on the list are repeated. It is expected over time that you improve your work on these tasks, that you bring more issues to therapy and you think more deeply about more issues. It is also important that you are able to demonstrate you are accepting responsibility for your conduct across the periods of time specified.

From time to time your therapists may provide you with some direct information. It is expected that over time you develop more initiative as a part of a new responsible lifestyle. That is, you will take the first step in identifying issues, working towards solutions and reflecting more upon the issues, together with your therapist.

This timeline is not a "formula" for the difficulties you face. If applied in a focussed way it can be used by your therapist to set out key steps and issues for therapy. The timeline tells you the kind of change we expect you to be making at different stages of your therapy and what you should have done by the end. Of course, a whole range of other issues and tasks will be important for you to bring into therapy depending upon you and your family's specific needs and situations. The matters outlined in the following pages are the basic expectations. You will need to set out in far more detail what other matters are relevant to your rehabilitation.

We would like to issue you with a word of caution: if you follow this outline rigidly - for instance, as if it is a text book to be worked through, it is likely your work will be shallow and 'miss the mark' in important ways. You would not be filling in details about yourself and your conduct. It is also important that you do not add to the pressures of your family, particularly your partner or spouse, by engaging them in a process of filling out your plan for therapy.

You will note there are four monthly intervals on this timeline. This is to coincide with the intervals for reviews of progress as set out in your orientation information.

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ASSESSMENT

- Provide an account which validates your victim's account and experience. That is, tell in your own words what you said and did in abusing your victim, including how often you did it and over what period of time. *
- Set goals.
- List things which get in the way of you taking responsibility and respecting others.
- Describe how you see yourself, and how you have been presenting yourself to others.
- Details of your behaviour towards others.
- Provide a broad picture of your lifestyle generally, including your deeply held beliefs.
- Be clear about the Treatment Agreement conditions and why they are important for you.
- Set standards (e.g. take 100% responsibility).
- Discuss your sexual beliefs, thoughts and practices in therapy. You will be asked to provide a sexual history of yourself during assessment.
- Identify practical assistance for those you have hurt.
- Prepare to face-up to your spouse/partner. This includes the abuse you have perpetrated, your planning for the abuse and your conduct from the time of disclosure up to, and including the period of your assessment at Cedar Cottage.
- Prepare to face-up to the siblings of your victim.
- Show some understanding of the impact of your actions on your victim and family.
- Set out your reasons for wanting treatment.
- Set out your goals for treatment - what you want to have achieved by the end of treatment.
- Plan for the first 4 months of therapy. This means setting goals for this period. Make a list of what you want to achieve in this period. Repeat this exercise for every period throughout your treatment.
- Set out your current and any past explanation for your abusive conduct.
- Establish standards for your conduct towards others.
- Think of who could be in your audience.

You are expected to continue to develop your account (referred to as 'Crime Description') throughout your treatment. The guidelines for developing your Crime Description are given in Appendix 3.

February 2007

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FOUR MONTHS

- Set clear goals, plan of action and standards for the period and show progress towards your goals.
- Focus on helping others, less on yourself.
- Follow up face-ups to victim’s mother. **
- Follow up face-ups to victim’s siblings.**
- Further develop reasons for conditions in Treatment Agreement. **
- Start developing your audience. **
- Set standards for yourself against which you can measure your conduct.**
- Begin to evaluate own conduct.**
- Set out explanations for abuse that you now hold.
- Review earlier explanations for abuse.
- Develop further understanding of the impact of your behaviour upon others (past and present).
- Name and identify in your own conduct aspects of power and control over others.
- Demonstrate progress through your actions, do not rely on words alone.
- Describe extent of abuse (sexual and other) including planning.
- Continue developing crime description to distinguish words and actions from thoughts, feelings and beliefs.
- Continue work on “facing-up” to others and self.
- Have a positive constructive approach to your treatment. This means volunteering information about yourself and your actions and discussing it. **
- Continue to evaluate yourself in treatment.**
- Keep daily log of sexual thoughts and practices.**
- Continue to keep your daily journal.

- Workbooks:
  Substantial progress “Who Am I & Why Am I in Treatment?” 
  “Maintaining Change” Phase 1 commenced.

** Also for 2 month review -- pay particular attention to this point but not to exclusion of other relevant issues for you.

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EIGHT MONTHS

- Set clear goals, plan of action and standards for the period and show progress towards your goals.
- Continue to keep daily journal and sex log.
- Continue to expand Crime Description. **A written copy of your Crime Description should be submitted for your 8 month review.**
- Continue to describe your tactics.
- Describe what is happening for you to be able to provide more details of your abusive conduct.
- Demonstrate that you think of the impact of your conduct on others.
- Continue the process of facing up.
- Have meetings with your audience.
- Become more clear about your beliefs, thoughts and feelings.
- Be more clear in your account of your conduct.
- Show that you are using individual and group therapy to address your abusive conduct and to make progress towards your goals.
- Show that you are continuing to evaluate yourself.
- Draw a distinction between present and past behaviour.
- Maintain accountability for your current conduct, bring information about your current conduct for review in therapy, including your interactions with significant others, particular the mother of your victim/your partner.
- Continue to identify the ways in which you can assist others and demonstrate that you are assisting them.
- Describe the ways in which you have justified your behaviour so far. Be more clear about what are excuses and what are responsible explanations.
- Submit workbook assignments in individual therapy regularly.
- Show that you are applying in your daily life what you learn from the assignments.

**Workbooks:**
‘Who Am I & Why Am I in Treatment?’ completed at 6 months.
‘Maintaining Change’ Phase 1 completed by 6 months, commenced Phase 2 and attended at least one workshop series at Cedar Cottage.
12 MONTHS

- Set clear goals, plan of action and standards for the period and show progress towards your goals.
- Continue to keep daily journal and sex log.
- Show that you are willing to bring to therapy things that you have been holding back.
- Expand your account of your planning and tactics in abusing.
- Identify past/current abusive practices within your intimate relationships.
- Continue to show that you are considering the impact of your conduct on others and assilling those whom you hurt.
- Plan/preparation well-advanced for your face-up to child victim.
- Further meetings with siblings commenced already.
- Set out ways in which you have invited others to be responsible for you or share your responsibility.
- Demonstrate empathy skills (that is, how you understand and feel for the experience of others), and what you do to not cause further distress/harm.
- Be ready to answer questions that your victim may have in an age appropriate manner.
- If relevant, consider supervised contact with children in depth and discuss this fully in therapy.
- Set out and evaluate your conduct towards child victim(s) and their siblings.
- Have set out how your actions have affected relationships within the family (i.e. relationships between others).
- Have commenced autobiography.
- Have meetings with your audience.

- Workbook:
  Submit assignments regularly.
  Progressing through Phase 2.
16 MONTHS

- Set clear goals, plan of action and standards for the period and show progress towards your goals.
- Continue to keep daily journal and sex log.
- Develop clear plan for future.
- Discuss your stance in relation to your future contact with the family where you abused.
- Meetings to discuss and look to implications for future between yourself and significant others.
- Have a clear plan in place to not re-abuse and review in therapy.
- Provide examples of changed lifestyle.
- Maintain full accountability for your current conduct.
- Face-up to your victim.
- Continue to face-up, in consultation with your therapist, to other family members, colleagues, friends.
- Update Crime Description.
- If you have been sexually, physically or emotionally abused in the past, be prepared to talk about this and its impact as part of your therapy. You must address this issue before you have full explanation for your choice to abuse.
- Autobiography well advanced.

- **Workbook:**
  Continue to submit assignments on time to complete the ‘Maintaining Change’ workbook by 18 months.
20 MONTHS

- Set clear goals, plan of action and standards for the period and show progress towards your goals.
- Continue to keep daily journal and sex log.
- If your family wish to reunite with you, or have contact with you, you should develop a plan, starting with meetings with the children's mother at Cedar Cottage.
- Have standards for future relationships.
- Have full explanation for your choice to abuse.
- Have fully developed your plan to not re-abuse by 18 months.
- Demonstrate empathy for your victim/s and others you have hurt.
- Bring together all aspects of your treatment and show how you are putting this into practice.
- Commence development of your MASS by 18 months and completed your MASS by 20 months.
- Meet with your MASS members at Cedar Cottage.
- Have your MASS in full operation, including evaluating how you are using it.
- Discuss in therapy your stance regarding apologies and forgiveness.
- Complete your autobiography and discuss it fully in therapy.

**Workbook:**
Complete all workbook assignments from 'Maintaining Change' by 18 months. Relapse Prevention Plan in place with ongoing review by 18 months.
TWO YEARS (24 MONTHS)

The period from 20 months to 2 years is mainly one in which you demonstrate your acceptance of responsibility. Major new areas for therapy are not anticipated as this is a period of putting all the things you have learned and developed into practice.

- Set clear goals, plan of action and standards for the period and show progress towards your goals.
- Continue to keep daily journal and sex log.
- Complete all nominated tasks.
- Demonstrate self-monitoring and practise your plan to not re-abuse.
- Demonstrate ongoing commitment to a non-abusive life.
- Demonstrate accurate self-evaluation of your conduct.
- Demonstrate empathy in a range of situations.
- Name tactics/planning/restraints and how you have overcome them in relation to your participation in therapy.
- Have relieved others of burdens they carry due to your abusive actions.
- Cease to undermine others' relationships.
- Have clear plans for future, including your plan for maintenance therapy.
- Continue to report on how you are using your MASS.
SAMPLE

UNDERTAKING

Section 23 – Pre-Trial Diversion of Offenders Act 1985

NEW SOUTH WALES
(Location of District Court)

Be it remembered that on (date) in the State of New South Wales (herein after called the Offender) personally came before the undersigned, one of Her Majesty’s Judges for the said State.

And whereas the said Offender has pleaded GUILTY before his trial, he personally acknowledges himself BOUND by the following undertakings:-

1. To participate in a special program for a period of TWO YEARS dating from (_____ ) as the Director of the Pre-Trial Diversion Program may require.

2. During the participation and pending the commencement of the participation, to comply with all reasonable directions given by the Director to the person in relation to:

   (i) the behaviour of the person (including access by the person to any other person or premises or place, whether or not the person has a legal or equitable interest in the premises or place.

   (ii) any matter prescribed by regulations; and

   (iii) any other matter which the Director thinks necessary or appropriate in the circumstances, and

3. To appear before the Court in relation to the matter when required by the Court to do so.

Taken and acknowledged by the said Offender on this date at (place) in the State of New South Wales before me:

---------------------------------------------------------------------------------  ---------------------------------------------------------------------------------
Judge of the District Court of NSW  (Person entering Undertaking)

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REVIEWING YOUR PROGRESS

GUIDELINES FOR PROGRAM PARTICIPANTS

An important aspect of your rehabilitation involves developing a practice of evaluating your actions, your thoughts, the way you deal with your feelings, the way you relate to others, etc. It is important that throughout your treatment, you evaluate yourself on a regular basis against the standards and goals you have set for your treatment and for your conduct in general. It is important that you do not limit the self-evaluation to the times when you have a formal review of your progress.

At the time of your review of progress you are asked to prepare and present your own evaluation of your utilisation of therapy, and to state whether you consider your progress to be satisfactory or unsatisfactory. Below we list some areas/matters/issues that you need to keep in mind when preparing your self-evaluation.

1. Take into account therapists’ previous reports of your progress and your own evaluation: consider whether your work in the current period of therapy shows that you have taken up the issues that were raised then.

2. Consider how you utilise therapy. This would involve considering the extent to which you prepare yourself for the sessions, the extent to which you are open with your therapists and your group, the extent to which you come forward with matters to discuss in therapy.

3. Consider your application of your standards, the extent to which you have been keeping your goals for treatment, and your goals and plan of action for the current period, in mind when working in therapy.

4. Consider how open you are in relation to your thoughts, feelings, how you make decisions, and how clearly you describe your actions. This is a measure of your accountability. It is important that you give clear examples when you are evaluating your openness.

5. Consider whether you have taken further steps to face-up to yourself and to face-up to others.

6. Consider how much progress you have made in developing a responsible explanation for your choice to perpetrate abuse.

7. Consider how much progress you have made in developing your relapse prevention plan. Give specific examples of those steps.

8. Consider your progress overall, determine whether your progress is satisfactory or unsatisfactory and anticipate what are the matters you need to address next.
APPENDIX 3

CRIME DESCRIPTION

This task, called “Crime Description” is an important and essential part of your treatment. At regular intervals you will be asked to prepare your crime description. The elements of this are set out below. The times at which you are to complete this task are:

1. At assessment.
2. 8 Months.
3. 16 Months.

Completion of the task at these times should reflect the work you have been doing in the period between. That is, it should not involve you in suddenly changing direction in your therapy. Your therapy in any period should relate in some way to the Crime Description task. If it does not relate to your therapy in the preceding period, you should discuss this with your therapist.

When you first came to Cedar Cottage you brought with you an account of your sexually abusive conduct. For most men clearly setting out this conduct and its effects upon others is very difficult. Some find it embarrassing, shameful, humiliating and so on. Often the picture emerges of conduct which is not consistent with the way people have thought themselves to be as fathers, as partners, as members of the extended family, as friends, etc. This task is aimed at clarifying the nature and extent of your conduct which has resulted in you seeking treatment. It is structured in such a way that not only your conduct is clear, but also what you told yourself about your conduct and its effect upon others, most importantly the children you sexually abused.

The Crime Description task is for you to set out, in writing, your sexually abusive actions. There is an expectation on the Program’s part that your Crime Description will be a growing one; unfolding and becoming more detailed and complete as you take further steps to own your own actions, to re-attribute responsibility for your conduct to yourself, and become more clear about the differences between excuses and responsible explanations.

Your Crime Description should include:

- What you said and did in carrying out the assaults.
- Your beliefs, thoughts (things you said to yourself) and feelings at the time of the assaults.
- What you said and did during the planning of the abuse.
- What you said and did around the time of disclosure.
- Your beliefs, thoughts and feelings during the planning and around the time of disclosure.
- The impact of your actions on others. That is, how the things you did and said have affected other individuals and their relationships. You should not limit yourself to thinking of the effects upon your direct victim(s) alone.

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There are many issues to be addressed in your Crime Description. Some of the questions you should attend to include:

- Has my account of what I said and did validated the statements made by my victim(s)?
- How old was my victim when I first started assaulting?
- How old was my victim when I first began thinking about my victim sexually?
- Have I been clear about how often I sexually assaulted?
- If I moved from one type of abuse to another or changed the type or nature of abuse over time, have I been clear about this?
- Have I clearly separated; (a) what I said and did (which my victim experienced) from (b) all the things that were going on inside me at the time (my thoughts, feelings and beliefs)?
- Have I been able to identify the distortions in my thinking patterns which were present?
- Have I left out any significant people or relationships in outlining the impact of my abuse?
- Have I described what my child victim(s) did and said?
- What did I do about this?
GOALS, STANDARDS, PLAN OF ACTION

GOALS

There are 2 types of goals:

1) **Approach** goals ("do" goals):
   What you want to achieve. For example:
   
   - To respect others
   - To be open about my actions.

2) **Avoidance** goals ("don't do" goals):
   What you want to prevent/not do. For example:
   
   - To not re-offend
   - To not keep secrets.

From the examples above, you can see that both types of goals are relevant to your treatment. You will set both "approach" ("do") goals and "avoidance" ("don't do") goals when you plan your work in therapy.

"Approach" ("do") goals tend to be more encouraging because you can track your progress. You can notice the steps you are taking towards your goal.

"Avoidance" ("don't do") goals are more "pass or fail". Avoidance goals are important. However, you need to make sure you do not depend on "avoidance" ("don't do") goals.

We suggest that you set more "approach" ("do") goals and fewer "avoidance" ("don't do") goals in your work at Cedar Cottage.

The rest of this section is about "approach" ("do") goals.
An “Approach” (“do’) Goal is:

- What you want to achieve through your efforts.
- What sort of person you want to be (through your efforts).
- What you are working towards.

Note: A goal is something you strive to achieve through your efforts. It does not depend on what others do, say or decide.

Example:

Think of your assessment. When you were going through assessment what goals did you have? It is likely that at least one of your goals was to be accepted into the Program.

You have achieved this goal.

Now think of how you came to achieve this goal. What did you do to achieve this goal?

- Goals may be general or they may be specific.

- After setting some major goals you may then set some smaller, though no less important goals, which cover fewer matters, and a shorter period of time.

For example, when you started treatment you set some major goals for what you want to have achieved by the time you complete treatment.

Example: **Goal:** To be a non-abusive person with a high level of respect for others and for myself.

In order to work towards that goal, you might have set some smaller goals:

Example: **By the end of the first 4 months of therapy, I will have a clearer and fuller account of my abusive actions.**

For some of your goals, you might decide to set clear standards to be able to measure whether your current thinking and current actions are moving you towards your goals.
STANDARDS

These notes may assist you to be clear about what a standards is and how to set your personal standards.

- Standards are rules to guide your behaviour and your thoughts.

- Most people have personal standards for how they live but do not spell them out. Those who have developed abusive lifestyles will find it useful in re-directing their lives to think about, list and spell out new standards.

- These standards should direct how you make decisions, relate to people, speak, assess situations.

- Your standards are your own. You may find that many of your standards will be similar to those of other men in the Program. You will also have standards which are different from those of other men in the Program.

- At Cedar Cottage you are expected to actively use your standards and to be clear about which standards you are using to make particular decisions.

- You may have standards that apply to all of your life. You may also have some for specific situations, for example, whom you will tell about your abuse. You can add more standards as you need to.

- As with standards used by manufacturers, e.g., to ensure that products achieve a certain level of quality, your standards should be measurable and specific.

  In setting a standard, you state what you will or will not do. In most cases, your standards would be observable, other people would be able to notice whether you are keeping to your standards or not.

  There are also standards that you set in relation to your thoughts and fantasies. Only you would know whether you are measuring up to these particular standards or not.

There is no one way to list your standards but the following may help:

- A standard should start with a rule or guideline for the sort of person you want to be, how you want to behave. For some aspects of your life, you will need to view your standards as rules rather than guidelines. Guidelines are more general, while rules are more strict, rules state clearly how you are going to conduct yourself.

- Standards relate to the goals you set out to achieve.

Some examples might look like this:

1. My Goal: I will be respectful towards others.
What does this mean?
In the way that I speak to, and think of, any person I meet I will keep in mind that they have the right to feel safe, they have the right to have their own opinion, the right to speak, be heard, have a different opinion from mine. They have the right to be safe from being degraded, intimidated, or pressured.

How will I know if I am applying this standard?
Am I allowing the other person to speak? Am I interrupting? Am I paying attention to them and listening? Have I crowded them or intimidated them? Am I behaving in ways that invite them to feel sorry for me? Am I being intrusive by what I think, say or do? You might list the signs that you will notice, and others will notice, if you are applying this standard.

My Standards to check whether I am progressing towards this goal:

- Keep appropriate boundaries in my thoughts and actions.
- Keep appropriate physical distance.
- Do not stare at the other person.
- Do not fix my gaze on parts of the person's body.
- Listen to what they say.
- Do not interrupt.
- Keep the volume of my voice at the level of a normal conversation.
- Check whether what I heard the person say is what they said.
- Check whether I am presenting myself as being unfairly treatment.
- Check my thoughts.


What does this mean?
I will put effort into my treatment. When I discuss my treatment with members of my audience I will give clear information, I will tell them clearly what I am doing in treatment. I will show it is important for me to keep to my treatment conditions. I will keep the work I do organised. I will read the Program guidelines and the work I have done, on a regular basis.

My Standards towards my goal:

- Spend 1 hour a day on my work for treatment.
- Think about what has come up in the therapy sessions.
- Throughout my day I will keep my treatment conditions in mind.
- Journal the main events of my day in a clear and straightforward manner.
- When making decisions, I will think how my decision may affect others.
- I will keep my therapy work/assignments organised.

Note:
• You may have more or fewer standards than those given in the examples. What
is important is that the standards mean something to you and that they help you
make progress towards your goals.

• When writing your standards you may decide that some of your standards need
to be broken down into 2 or more separate ones.

• For each standard you develop you need to know why it is important for you.

**PLAN OF ACTION:**

Your **plan of action** sets out what you are going to do, what steps you are going to
take, to **achieve your goal/s**.

For example:

**Goal:** By the end of the first 4 months of therapy, I will have a clearer and
fuller account of my abusive actions.

**Plan of Action:**

• Update my Crime Description.
• Do 3 chapters of the workbook.
• Prepare a face-up for my victim’s mother.

For each part of your plan of action you would set standards. It is best to write down
your standards. Most importantly you need to have your standards clear in your
mind.

Your standards will help you measure whether your actions and your work in
treatment are in keeping with what you want to achieve. Applying your standards is
a way of checking how you are going about doing what you need to do to progress
towards your goals.

JANUARY 1993

BACKGROUND

The Evaluation of the NSW Pre-Trial Diversion of Offenders Program (Child Sexual Assault) was undertaken at the request of the PTDP Board of Management by Professor Tony Vinson, University of New South Wales, from December 1991 - April 1992. It is an independent evaluation.

The Senior Policy Implementation Manager, Health Services Implementation Branch, is chairperson of the Board of Management.
Other members of the Board are representatives of:

- The Minister for Community Services
- The Commissioner of Police
- The NSW Child Protection Council
- The Attorney General
- The Board of the Western Sydney Area Health Service.

The evaluation followed completion of the pilot program in late 1991 and a legislative requirement that the program be evaluated.

The NSW PTDP was established at the recommendation of the NSW Child Sexual Assault Task Force in 1985.

In November 1985 the Pre-Trial Diversion of Offenders Act was passed with bipartisan support by the NSW Parliament. The legislative was not proclaimed until May 1989.

The treatment program was developed by a working party of the NSW Child Protection Council (CPC). The NSW CPC working party prepared the program to be known as the "special program" as defined by the Act.

The general goals of the Programme are:

1. The protection of children.
2. The prevention of further child sexual assault in families where this has occurred.
3. An increase in responsible thinking and behaviour by offenders.

The more specific objectives of the Programme are to provide:

1. Treatment for persons charged with child sexual assault offences referred by the Director of Public Prosecutions.
2. Treatment to other members of an offender's family.
3. Treatment which enables child victims to resolve the emotional and psychological concerns which arise from their victimisation; and
4. A treatment which enables other family members, such as non offending parents and siblings of the child victims, to resolve the emotional and psychological concerns which have arisen for them as a result of the sexual victimisations within their family.

Although the Programme is called an "offender" programme this title does not reflect the work done in child protection in providing ongoing treatment to victims and other family members. As indicated in the general goals of the PTDP the protection of children is the primary goal of the Programme.

The "special program" was approved by the Minister for Health (20 November 1986), the Minister for Youth and Community Services (8 December 1986) and the Attorney-General (11 March 1987).
The terms of reference of the evaluation included two major questions:

i) how successful has the PTDP been during its pilot period?

ii) what improvements and efficiency might be achieved in the years ahead?

The evaluation report has clearly documented the success of the PTDP and proposed a series of recommendations to ensure its continuation and expansion throughout NSW. At the same time, proposed amendments to the original legislation and regulations have been prepared by the Attorney-General's Department. At the time of preparing this document these amendments had been prepared for the Parliament.

**ISSUES**

The report makes it clear that it has focussed on the role of PTDP within the context of the criminal justice system and political and community attitudes towards treatment programs for child sexual assault offenders.

The PTDP, as acknowledged by Professor Vinson, addresses the safety and welfare of the children as paramount and endorses the nature of the treatment program in these critical areas.

The report has focussed intentionally on offenders in an attempt to resolve policy questions for Government on the relevance of programs for offenders in NSW.

In particular, the report has stated:

"In evaluating the present cost of the Diversion Program it must again be emphasised that it was not instituted exclusively, or even primarily, as an alternative means of treating offenders. Uppermost in the minds of the legislation was the protection and well-being of victims and others who suffer indirectly as a result of sexual abuse. Yet, even if the cost comparisons are confined to the bottom line of the cost of managing offenders, the bonus of an intensive genuinely corrective program is purchased at a cost almost identical with that of the most probable alternative mix of standard custodial or community supervision programs".
Recommendations from the evaluation report identify issues requiring attention at two levels. In the first instance it will not be necessary to address all issues. However, the following issues require immediate action:

- management and administration, including role of the Board of Management
- future of PTDP
- proposed expansion of PTDP

These immediate issues will be addressed below in comments on report recommendations.

**Comments on recommendations:**

**Recommendation 1**

"Within six months of the tabling of this Review, a Charter of Service Standards should be developed by the Director and staff of Cedar Cottage and submitted to the Board of Management for its approval."

**Comment:** The development of a Charter of Service Standards is endorsed.

**Recommendation 2**

"Written and videotaped case record material should not routinely be offered to the DPP when breach reports are furnished by the Director of the Diversion Program."

**Comment:** Endorsed in principle. However the programme is under a positive obligation to provide the Court with the fullest possible account of any breaches of undertaking.

**Recommendation 3**

"Upon admission to the Diversion Program, offenders should be informed that it may be necessary for investigative staff to monitor their fulfilment of bail conditions, especially those relating to their non-contact with victims. Accordingly, a video recording of the offender should be made to facilitate his identification by investigative staff, should that become necessary."

**Comment:** Endorsed.

**Recommendation 4**

"Other than to attend emergencies, police and investigative staff should not enter the premises of the Diversion Program."

**Comment:** This recommendation is unduly restrictive. Police do enter the premises of the Programme for legitimate business, for instance, attendance at the Board meeting
and other meetings. The overriding principle here is that the presence of such personnel must not intrude upon the clients and their therapy.

**Recommendation 5**

"The Diversion Program should be administratively incorporated within the Western Sydney Area Health Service with the Director of the Diversion Program reporting directly to the Deputy Chief Executive Officer of the Area Health Service who should remain a member of the Advisory Board (see Recommendation 7). The Deputy CEO should oversee the administrative, financial and personnel arrangements within the Diversion Program. The Board should have responsibility for setting the broad policy, procedures and therapeutic direction of the Program, the shaping of its external relations and the development of any proposals regarding relevant legislation."

**Comment:** The recommendation to incorporate the PTDP within the Western Sydney Area Health Service (WSAHS) is not endorsed.

Discussions with the WSAHS suggests that while it would agree to the continuation of its financial and administrative role in the management of the PTDP, it would be inappropriate for it to accept any other policy related responsibilities.

Successful operation of the Special Programme requires a management structure that:

- Ensures that the Special Programme fulfils the requirements of the legislation in both its corrective and treatment aspects.
- Facilitate co-operation between the relevant departments and agencies.
- Monitors the Programme's operations.

A more satisfactory arrangement would involve the following:

- A NSW Department of Health PTDP advisory committee be established. The committee to be established by Ministerial appointment on a two yearly basis.

**Composition of the Committee.**

Chairperson: NSW Department of Health.

- Department of Community Services
- Attorney General's Department
- NSW Police Service
- Child Protection Council
- WSAHS (Deputy CEO)
The functions of the new Committee shall be:

1. To formulate policy and monitor the operation of the Programme.
2. To report annually to the Minister for Health, the Minister for Community Service and the Attorney General on the operation, efficiency and effective of the Special Programme in respect of its obligations under the Legislation.
3. To contract the day to day administration of the Special Programme by the Department of Health to the Western Sydney Area Health Service.
4. To select the Director and Deputy Director and ensure that appropriate performance appraisals are in place.

The Director is to act as executive officer to the advisory committee and attend and participate in all meetings and deliberations of the committee.

The Director shall report to the chairperson of the committee. The Director shall be responsible to a senior officer of the WSAHS for the administration and financial management of the programme.

The Responsibilities of the WSAHS are to include:

1. Staff and personnel functions and associated administrative support.
2. Financial reporting.
3. Provision of and maintenance of the premises.
4. Other as required.

Recommendation 6

"Clients of the Program should be informed via the Program Brochure and by other means, that they can complain to a Deputy DEO of the Area Health Service if they have a grievance. When considering such a complaint, the Deputy CEO should be assisted by either of two independent therapist consultants nominated by the Advisory Board."

Comment: The proposed grievance procedure is considered inappropriate. The suggestion to inform clients better about the existing grievance procedure is considered appropriate. There should be further development of formal grievance procedures for clients in conjunction with the committee.

Recommendation 7

"An Advisory Board should replace the existing Board of Management when the Diversion Program is administratively incorporated within the Department of Health. However, the same range of disciplinary and organisational interests should be represented on the Advisory
Board which should continue to report to the Ministers of Health and Community Services and the Attorney-General on the efficiency and effectiveness of the scheme."

**Comment:** The organisational structure should be reviewed immediately as proposed in comments under Recommendation 5.

**Recommendation 8**

"The brochure used to acquaint potential clients with the Diversion Program should be modified to explain the frequently onerous aspects of the Program mentioned by existing clients and outlined in the body of this report."

**Comment:** An information kit has been produced to explain the Programme in more detail to offenders, victims, their mothers and siblings.

**Recommendation 9**

"Clinical staff should be encouraged to avoid the use of unnecessarily complicated language in their work with clients and clinical supervision should include discouragement of the use of jargon."

**Comment:** It is difficult to assess the extent to which therapeutic language is jargonistic. The recommendation implies that PTDP staff are not aware of such issues. This is not a justified criticism.

**Recommendation 10**

"The first individual therapist to whom a sex abuse victim relates after entering the Diversion Program must be a female. Later transfer to a male therapist should only occur after careful consultation and with the agreement of the victim."

**Comment:** There is some clinical justification to support access by a female victim to a female therapist in the first instance. However, the availability of female therapists cannot be guaranteed and it must be left to the discretion and sensitivity of PTDP staff to make informed decisions in particular circumstances.

**Recommendation 11**

"To help ensure stability of staffing, with resultant benefits for the therapy provided to victims, family members and offenders, staff gradings should be revised along the lines recommended in the body of the report."

**Comment:** The specialised nature of the clinical work being conducted needs to be recognised and staff gradings should reflect this.

**Recommendation 12**

"An additional position of Research Assistant (estimated total cost of $35,000 p.a.) should be
funded for two years to enable basic data to be compiled and evaluation studies commenced. During this pilot period applications should be made to sources of outside funding and links established with potential research collaborators."

**Comment:** Endorsed. Action to be taken when funds available.

**Recommendation 13**

"A taxi voucher system be instituted to enable victims to attend Cedar Cottage and other nominated treatment centres. The vouchers to be allocated at the discretion of the Director (estimated annual cost $15,000)."

**Comment:** The specifics of this proposal needs further investigation.

**Recommendation 14**

"An approach should be made to the Chief Stipendiary Magistrate to gain the co-operation of Magistrates in drawing the attention of eligible offenders and their legal representatives to the Diversion Program."

**Comment:** Endorsed. The board will continue to facilitate appropriate awareness of the programme.

**Recommendation 15**

"The Diversion Program should gradually be extended to areas of greatest demand throughout New South Wales, using qualified, appropriately prepared and continuously supervised professional staff."

**Comment:** The expansion of the PTDP throughout NSW to areas of greatest need would require extensive planning, consultation and obvious resource commitments. Such a move must take into account the complexities of such a proposal. The report does not adequately address in sufficient depth the implications of this proposal.

It is a view of the Board of Management that resources be identified to employ a consultant to undertake a project to determine the feasibility for an expansion of the PTDP throughout NSW.

**Recommendation 16**

"Consultations should take place with the Ministry of Justice to enable the Director of the Diversion Program to assist community corrections officers to adapt and apply key principles of the Diversion Program to the field of community corrections."

**Comment:** Endorsed.
SUGGESTED ACTION.

1. To set in place a formal management structure for the PTDP as suggested in comments to Recommendation 5.
   (i) A NSW Department of Health PTDP Advisory Committee be established by Ministerial appointment.
   (ii) The Chairperson of the Committee shall be from the NSW Department of Health.
   (iii) Other members of the Committee shall be representatives of: the Minister for Community Services, the Attorney General, the Commissioner of Police, the NSW Child Protection Council, the Board of the Western Sydney Area Health Service.

The present Board to continue until 30th June, 1993 with a new Board taking effect from 1st July, 1993.

2. A service contract be entered into with the Board of the Western Sydney Area Health Service for the provision of administrative services to the PTDP.

3. That the NSW Government identify resources to enable the Child Protection Council to undertake a study on the feasibility of an expansion of PTDP throughout NSW.

The study would address the following:

. identification of a range of service options to expand family treatment offender programs in NSW. These options should all incorporate a child protection focus.

. identification of counselling/therapeutic methodologies appropriate for child protection focussed sex offender treatment programs.

. full consultation with relevant Departments and agencies, including community-based organisations.

. resource implications

. management issues

. human resources issues
- professional education/professional development
- timelines for implementation
- proposed locations according to priority need.
Appendix F: Protocol for Sex Offender Survey Project

Protocol for Sex Offender Survey Project

1) DEMOGRAPHICS

Offender's Name: __________________________________
Police CNI: ___________ CC File: _________________
Date of Birth (year/month/day): ____________________
Suburb: __________________
Date of referral: _______________________
If accepted into treatment program -
Date completed: _______________ OR
Date breached /withdrawn: __________
Race: Caucasian   Aboriginal: Status / Non-☐ Status

Current Status:
☐ Code 0 - incarcerated
☐ Code 1 - detained
☐ Code 2 - day parole
☐ Code 3 - full parole
☐ Code 4 - stat release
☐ Code 5 - warrant expiry

1.1 History of physical or emotional abuse (before age 16)
Details:_____________________________________________________________________
___________________________________________________________________________
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☐ Code 0 - Offender has no history of physical or emotional abuse.
☐ Code 1 - Offender has witnessed either physical or emotional abuse but was not a direct victim.
☐ Code 2 - Offender was a victim of either physical or emotional abuse
☐ Code 99 - Insufficient Information
Physical Abuse: beatings, pushing, and other contact activities except sexual contact

Emotional Abuse: neglect, verbal abuse, threats, break objects, control finances etc.

1.2 History of sexual abuse (before age 16).

Details:_____________________________________________________________________
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☐ Code 0 - Offender has no history of sexual abuse.
☐ Code 1 - Offender has witnessed sexual abuse but was not a direct victim (e.g. observed his father/brother sexually abusing other family member/s)
☐ Code 2 - Offender was a victim of sexual abuse.
☐ Code 99 - Insufficient Information

Relationship to offender: ___________________________
Gender of offender: _______________________________
Age of victim: ___________________________________

Type of sexual abuse: YES NO
Penetration ☐ ☐
Non Penetration ☐ ☐

1.3 Intellectual Functioning

☐ Code 0 - No history of intellectual handicap; IQ is average to high
☐ Code 1 - Some intellectual handicap but is able to live in the community with some support and help; IQ is low average
☐ Code 2 - The offender requires regular supervision as he is unable to meet minimal demands without it (eg. hygiene, meals, daily planning); IQ borderline or below
☐ Code 99 - Insufficient Information
1.4 **Thought Disorder** (psychotic disorder, schizophrenia)

- **Code 0** - No history of thought disorder
- **Code 1** - History of diagnosed thought disorder which is in remission (i.e. no active symptoms)
- **Code 2** - Presence of diagnosed thought disorder which is or is not controlled by medication.
- **Code 99** - Insufficient Information

1.5 **Affective Disorder** (depressive or manic depressive illness)

- **Code 0** - No history of affective disorder
- **Code 1** - History of diagnosed affective disorder which is in remission (no active symptoms)
- **Code 2** - History of affective disorder or organic mental disorder (e.g. brain damage due to accident or alcohol abuse) which is or is not controlled by medication.
- **Code 99** - Insufficient Information

1.6 **Employment**

- **Code 0** - Overall, able to maintain steady employment: look for consistent employment, may have short periods (months) of unemployment or time in between jobs but generally able to secure employment eventually
- **Code 1** - Evidence of sporadic or seasonal employment only
- **Code 2** - Difficulty maintaining employment
- **Code 99** - Insufficient information

1.7 ** Substance abuse - use of disinhibitors**

- **Code 0** - No history of drug or alcohol abuse.
- **Code 1** - History of alcohol and/or drug abuse but these were not linked to the commission of the sex offence.
- **Code 2** - Alcohol and/or drug abuse and alcohol or drugs were linked to the commission of one or more sexual offences.
- **Code 99** - Insufficient Information

1.8 **Social skills**

**Code 0** - Has adequate interpersonal skills and has no history of disturbed functioning in this area. Is not socially anxious.

**Code 1** - Has some problems in this area. For example, he may have a few friends but demonstrate a tendency to withdraw and become silent in social situations. He may know how to be social with others but reports anxiety which makes it difficult for him to interact with others as effectively as he would like.

**Code 2** - The offender has very few social skills and is extremely socially anxious. He has few if any friends and tends to withdraw entirely from social contact with others.

**Code 99** - Insufficient Information
2) CRIMINAL HISTORY

History of Offending (other than sexual)

<table>
<thead>
<tr>
<th>Types of Offences</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault</td>
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<tr>
<td>Robbery</td>
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<tr>
<td>B&amp;E</td>
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<td>PCA</td>
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<tr>
<td>Drug &amp; Alcohol</td>
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<tr>
<td>Domestic violence</td>
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<tr>
<td>Subject of an AVO</td>
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</tr>
</tbody>
</table>

2.1 Aggression directed at animals or objects.

- Code 0 - No recorded history of fire setting or cruelty to animals.
- Code 1 - One incident of fire setting or cruelty to animals.
- Code 2 - More than one incident of fire setting or cruelty to animals.

2.2 History of Violence against spouse, common law partner, or significant others

Note: use the definitions of physical and emotional abuse in Item 1.1 to code this item

- Code 0 - No history of physical, sexual, or emotional abuse of spouse or significant others
- Code 1 - Some history of physical, sexual or emotional abuse of spouse or significant others
- Code 2 - Extensive history of physical, sexual, or emotional abuse of spouse or significant others
- Code 99 - Insufficient Information

2.3 Escalation of sexual violence (increase in the frequency and/or intensity of violence)

- Code 0 - No pattern or suggestion of escalation
- Code 1 - Evidence of some escalation
- Code 2 - Significant escalation
- Code 3 - The first sexual offence was very violent
- Code 99 - Insufficient Information

2.4 Range of sexual offending

Note: Types of sex offences are general categories of sex offences and are distinguished based on things like victim gender, whether the victim is a child or adult, and degree of intrusiveness (e.g.: contact vs non-contact).

- Code 0 - There has been little, if any, variation in the offence behaviour. The offender commits one type of offence (e.g. the offender commits indecent exposure only).
Code 1 - The offender has committed a limited number of acts. The offender commits two types of offences (e.g. indecent exposure and invitation to sexual touching).

Code 2 - There have been a variety of offences and illegal sexual behaviours. The offender commits three or more types of offences (e.g. sexual touching, sexual harassment, sexual assault).

Code 99 - Insufficient Information

2.5 Type of Sex Offender (use criminal history and index offence)

Code 0 - Incest offender: intrafamilial offences against children including biological children, step children, nephews, nieces, grandchildren, or children who have established relationships with the offender

Code 1 - Adult Rapist: sexually assaults adults (male or female)

Code 2 - Paedophile: child victims, primarily extrafamilial

Code 3 - Mixed Offender: sexual assault against both adult and child victims

Code 99 - Insufficient Information

3) INDEX OFFENCE:

Details of offence:
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Number of occasions: ________________________
Duration: __________________________________ (e.g. once per week for 12months)
Number of charges: __________________________
Number of disclosures of other offences:

<table>
<thead>
<tr>
<th></th>
<th>Sexual</th>
<th>Other Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>At referral</td>
<td>______</td>
<td>_____________</td>
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<tr>
<td>During assessment</td>
<td>______</td>
<td>_____________</td>
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<tr>
<td>In treatment</td>
<td>______</td>
<td>_____________</td>
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</tbody>
</table>
3.1 **Nature of the index offence:**

- **Code 0 - sexual:** the index offence is any sexual offence including non-sexual offences with sexual connotations
- **Code 1 - nonsexual:** the index offence is nonsexual, however the offender has a history of sexual offending

Note: if the index offence is nonsexual Items 3.2 through 3.12 will not be scored

3.2 **Degree of sexual contact:**

- **Code 0** - Offence was a "no contact" type of offence (e.g. indecent exposure, obscene telephone calls, peeping).
- **Code 1** - Offence involved sexual touching either underneath or on top of clothing.
- **Code 2** - Offence involved vaginal/anal penetration with body parts or objects and/or the offence involved oral sex.
- **Code 99** - Insufficient Information

3.3 **Nature of the sexual activity** - check all that apply

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<tr>
<th>Completed</th>
<th>Attempted</th>
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</tbody>
</table>

3.4 **Number of victims.**

Record the number of victims: ______

3.5 **Relationship to victim:**

Name of Victim: __________________________

- **Code 0** - The victim(s) is a member of the offender's immediate household (eg. residing with the offender) or related biologically to the offender.

**Number of Victims:** ______
Code 1 - The victim is known to the offender, but does not live in the offender's immediate household nor is the victim related biologically to the offender.
Number of Victims: _________

Code 2 - The victim is not otherwise known to the offender.
Number of Victims: _________

Code 99 - Insufficient Information
Number of Victims: _________

NOTE: Please consult the project investigator if the relationship is unclear.

3.6 Sex of victim

Code 0 - Female victim(s) only
Code 1 - Male victim(s) only
Code 2 - Both Male and Female Victims
Code 99 - Insufficient Information

3.7 Age of victim:

For one victim, record the age of the victim: ______
For multiple victims, record the age of the youngest victim: _________
and the age of the oldest victim: _________

If the age is unknown, insert a term describing the victim's age (eg. infant, toddler, preschool, adolescent, adult etc.).

3.8 Premeditation:

Code 0 - The offence was unplanned and impulsive.
Code 1 - There is some evidence that the offence was planned.
Code 2 - The offence was clearly planned.
Code 99 - Insufficient Information

3.9 Physical violence or threat:

Code 0 - There has been no use of threats or physical force to secure the victim's compliance, although bribes or treats may be used

Code 1 - There has been the use of threats or intimidation, but NO threats of physical violence. For example, the offender may have told the victim "If you don’t do this, I will be angry/hurt and/or the family will break apart" etc.

Code 2 - Physical force or threat of physical force was employed to obtain the victim's compliance.

Code 3 - Violence beyond that which was be necessary to secure the victim's compliance was employed or violence has been eroticised.

Code 99 - Insufficient Information
3.10 Use of a Weapon:
Code 0 - no weapon used
Code 1 - blunt object used
Code 2 - sharp object used
Code 3 - firearm used
Code 4 - other weapon used
Code 99 - insufficient information

3.11 Degree of Physical Injury to Victim (code the highest degree in description of injury to victim)
Code 0 - minor physical harm (the victim required minimal medical care)
Code 1 - moderate physical injury (the victim may have required medical attention at a hospital but was not admitted)
Code 2 - substantial physical injury (a short term hospital stay may have been required)
Code 3 - very extensive physical injury (long term medical care and/or rehabilitation required)
Code 4 - caused death
Code 99 - insufficient information

3.12 Degree of Psychological Injury to Victim (code the highest degree in description of injury to the victim)
Code 0 - minor psychological harm (the victim required minimal psychological/psychiatric care, the victim experienced minimal disturbances in their daily functioning)
Code 1 - moderate psychological injury (the victim may have required some follow up counselling/psychological support but regular/ongoing therapy was not required, disturbances to daily functioning were moderate)
Code 2 - substantial psychological injury (regular/ongoing therapy may have been required, some difficulty returning to normal daily functioning however the victim was able to resume activities/responsibilities)
Code 3 - very extensive psychological injury (psychological symptoms may include intrusive thoughts that seriously disrupt functioning, suicide attempts, admissions to a mental health hospital, or PTSD symptoms or diagnosis)
Code 99 - insufficient information

3.13 Factors Leading up to the offence (check off all that apply)
- sexual gratification, deviation
- jealousy
- rejection
- heated argument
- revenge
- robbery/economic motive
- claims innocence
- intoxicated, drug/alcohol abuse
angered by someone/something
claims victim consented
can't explain / doesn't know why
doesn't remember
love/emotional need / loneliness
not perceived as wrong/ harmful
other, specify: ____________________

3.14 Employment Status at the time of the current offence - select one category
Code 1 - employed (includes self-employed)
Code 2 - unemployed
Code 3 - student
Code 4 - disability pensioner
Code 5 - retired
Code 6 - other, specify: ____________________
Code 99 - insufficient information

3.15 Marital Status at time of current offence
Code 0 - single/ never married
Code 1 - common-law marriage
Code 2 - legal marriage
Code 3 - separated
Code 4 - divorced
Code 5 - widowed
Code 99 - insufficient information

4) Treatment for sexual offending
During the assessment phase did the offender provide “Face-ups” to:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>☐</td>
</tr>
<tr>
<td>Child victim</td>
<td>☐</td>
</tr>
<tr>
<td>Siblings</td>
<td>☐</td>
</tr>
<tr>
<td>Others</td>
<td>☐</td>
</tr>
</tbody>
</table>

During the treatment phase did the offender provide “Face-ups” to:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>☐</td>
</tr>
<tr>
<td>Child victim</td>
<td>☐</td>
</tr>
<tr>
<td>Siblings</td>
<td>☐</td>
</tr>
<tr>
<td>Others</td>
<td>☐</td>
</tr>
</tbody>
</table>

Did the offender’s “Face-up” match or extend the victim’s complaint?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Match</td>
<td>☐</td>
</tr>
<tr>
<td>Extend</td>
<td>☐</td>
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</tbody>
</table>
Details:___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
_________________________________________________________________________

4.1 Status of Sex Offender Treatment
Code 0 - completed treatment
Code 1 - treatment is ongoing
Code 2 - treatment was started but was incomplete
Code 3 - treatment has been recommended or requested, but not begun
Code 4 - the subject refused to participate in treatment
Code 99 - Insufficient Information

4.2 Type(s) of Treatment Completed (check off all that apply)
- Substance Abuse treatment (eg. OSAPP)
- Cognitive Skills
- Anger Management (eg. ABC)
- Sex Offender Treatment (eg. Clearwater, Parkland Wellness, Alpine Wellness)
- Family Violence
- Marital Counselling (eg. relationships)
- Individual Counselling
- Educational Upgrading
- Vocational Upgrading
- Aboriginal Programming
- Other - Specify the number of other programs: __________________________
- No evidence that any programming has been completed

4.3 Shares information.
Code 0 - The offender's and the victim's accounts of the offence match closely. The offender may even contribute information not included in the official record of his offence.
Code 1 - Shares most important details regarding his offences but there are some noticeable and important discrepancies with the victim's accounts. Some details are withheld.
Code 2 - The offender gives only the most vague and cursory account of his offence behaviour and will not present details.
Code 99 - Insufficient Information

4.4 Acceptance of responsibility
Code 0 - Accepts responsibility for the offence.
Code 1 - Accepts partial responsibility for the offence. For example the offender states that he committed the offence but cites a number of mitigating factors such as personal or marital problems.

Code 2 - Fails to accept responsibility for offence. For example, the offender may claim that he was seduced, or that the victim complained only to get money or revenge. May state that the victim actually enjoyed the assault.

Code 99 - Insufficient Information

5) Quality of Sex Offender Programming treatment reports

5.1 Sex Offender Treatment Report(s) was (were) available:
☐ yes
☐ no, explain: ________________________________

5.2 Location of Sex Offender Treatment (check all applicable):

☐ Other Institution, specify: ______________________
☐ Community

5.3 Does the treatment report include the following information?
(rate the report produced after the most extensive sexual offender treatment the offender had completed in the Prairie Region):

| Identification of Areas of Risk / Risk Factors | 0 | 1 | 2 | 3 |
| Treatment Progress | 0 | 1 | 2 | 3 |
| Impact of Treatment / Change in Risk Level After Treatment | 0 | 1 | 2 | 3 |
| Recommendations for follow up and management of offenders | 0 | 1 | 2 | 3 |
| Sexual Arousal Assessment (Will vary over time at CC) | 0 | 1 | 2 | 3 |

0 no The information was not present in the report.

1 poor The information was given in the report, however it was either unsupported or unclear.

2 some There was some information in the report. Information may not have been as thoroughly explained as it could have been.

3 yes The information was in the report. It was clear and complete. Statements made were thoroughly explained and supported.
5.4 Demonstration of responsibility

Validate/Face-up to:

- Child victim
- NOP
- Sibling
- Own parents
- Employers (as required)
- Others
Appendix G: Family Reunification Coding Instrument

CC File #
________________________________________

Therapist:
________________________________________

Date started treatment:
________________________________________

Date completed treatment:
________________________________________

Type of relationship (offender/victim): Biological Father / Stepfather / Other

Victim DOB:
________________________________________

Age of Victim  Start of Abuse  __________

Disclosure  ______________

Person child first disclosed to: Mother / Sibling / Friend / Other

History of separation between parents: Y / N / NA

Details (include when they separated, how long they separated for etc):
________________________________________

________________________________________

________________________________________

View on reunification

Strongly Opposed = -2

Somewhat Opposed = -1

Unsure/Neutral = 0

Somewhat in Favour = 1

Strongly in Favour = 2

No Information/Data Missing = 9
At Assessment

Offender:

NOP:

Victim:

At beginning of Treatment

Offender:

NOP:

Victim:

View on Reunification @ Tx completion:

Offender:

NOP:

Victim:

Note if view on reunification changed throughout treatment, include approximately when (i.e. 6 months into treatment) and any reasons given:
Attempted Reunification: Y / N / NA

Date: ____________________________

Currently Reunified (Offender/NOP): Y / N / NA
Victim in home (with Offender/NOP): Y / N / NA
Other siblings in home: Y / N / NA
Reunification with CC Support: Y / Other / None

If No Reunification:

Contact between Offender/NOP: Y / N / NA
Frequency: ____________________________
Mode of contact: ____________________________

Contact between NOP/Victim: Y / N / NA
Frequency: ____________________________
Mode of Contact: ____________________________

Contact between Victim/Offender: Y / N / NA
Frequency: ____________________________
Mode of Contact: ____________________________

Contact between Victim/Siblings: Y / N / NA
Frequency:

Mode of contact:

Length of Relationship between offender and NOP @ time of disclosure (in months if possible):

Treatment completed on time: \( Y \) / \( N \) – Ext

Breaches: \( Y \) / \( N \)

If \( Y \), # of breaches:

Details:

Evidence of NOP sexual abuse counselling: \( Y \) / \( N \)

Sexual abuse counselling with: CC / OTHER

Length of counselling:

Number of sessions:
Evidence of victim sexual abuse counselling: Y / N

Sexual abuse counselling with: CC / OTHER

Length of counselling:

Number of sessions:
Appendix H: Family Reunification Coding Instrument for Treatment Progress

<table>
<thead>
<tr>
<th>REVIEW (in months)</th>
<th>4</th>
<th>8</th>
<th>12</th>
<th>16</th>
<th>20</th>
<th>24</th>
<th>28</th>
<th>32</th>
<th>36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal # 1</td>
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<td>Goal # 5</td>
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<td>Goal # 12</td>
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<td>Satisfactory / Unsatisfactory</td>
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</tr>
</tbody>
</table>

99 = no information  
1 = no progress toward goal  
2 = some / limited progress toward goal  
3 = good progress toward goal  
4 = achieved goal
### Appendix I: Expanded Disclosure Data Collection Sheet

#### Victim's Account

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>CC File: _______</th>
<th>Therapist: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship to offender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age of victim at first abuse:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong># of occasions:</strong></td>
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<tr>
<td><strong>Frequency:</strong></td>
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<tr>
<td><strong>Duration:</strong></td>
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</tr>
</tbody>
</table>

**Location of abuse:**
- [ ] Victim’s bedroom
- [ ] Offender’s bedroom
- [ ] Lounge room
- [ ] Bathroom
- [ ] Other room in victim’s house
- [ ] Offender’s house (separate from victim’s)
- [ ] Car
- [ ] Holiday location
- [ ] Other: ___________________________

**Nature of abusive contact:**
- [ ] Exposing/exhibiting
- [ ] Invitation to sexual touching
- [ ] Touching/fondling
- [ ] Kissing
- [ ] Digital penetration
- [ ] Oral sex (by offender)
- [ ] Oral sex (forced victim)
- [ ] Genital to genital contact, no penetration
- [ ] Vaginal intercourse
- [ ] Anal intercourse
- [ ] Other: ___________________________
- [ ] Mutual

#### Pre-Assessment Account

<table>
<thead>
<tr>
<th>Age of victim at first abuse:</th>
<th># of occasions:</th>
<th>Frequency:</th>
<th>Duration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Location of abuse:**
- [ ] Victim’s bedroom
- [ ] Offender’s bedroom
- [ ] Lounge room
- [ ] Bathroom
- [ ] Other room in victim’s house
- [ ] Offender’s house (separate from victim’s)
- [ ] Car
- [ ] Holiday location
- [ ] Other: ___________________________

**Nature of abusive contact:**
- [ ] Exposing/exhibiting
- [ ] Invitation to sexual touching
- [ ] Touching/fondling
- [ ] Kissing
- [ ] Digital penetration
- [ ] Oral sex (by offender)
- [ ] Oral sex (forced victim)
- [ ] Genital to genital contact, no penetration
- [ ] Vaginal intercourse
- [ ] Anal intercourse
- [ ] Other: ___________________________
- [ ] Mutual

#### Crime Description at end of Assessment

<table>
<thead>
<tr>
<th>Age of victim at first abuse:</th>
<th># of occasions:</th>
<th>Frequency:</th>
<th>Duration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Location of abuse:**
- [ ] Victim’s bedroom
- [ ] Offender’s bedroom
- [ ] Lounge room
- [ ] Bathroom
- [ ] Other room in victim’s house
- [ ] Offender’s house (separate from victim’s)
- [ ] Car
- [ ] Holiday location
- [ ] Other: ___________________________

**Nature of abusive contact:**
- [ ] Exposing/exhibiting
- [ ] Invitation to sexual touching
- [ ] Touching/fondling
- [ ] Kissing
- [ ] Digital penetration
- [ ] Oral sex (by offender)
- [ ] Oral sex (forced victim)
- [ ] Genital to genital contact, no penetration
- [ ] Vaginal intercourse
- [ ] Anal intercourse
- [ ] Other: ___________________________
- [ ] Mutual
<table>
<thead>
<tr>
<th>Crime Description at 8 months</th>
<th>Crime Description at 16 months</th>
<th>Crime Description at 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of victim at first abuse:</td>
<td>Age of victim at first abuse:</td>
<td>Age of victim at first abuse:</td>
</tr>
<tr>
<td>______________________________</td>
<td>______________________________</td>
<td>______________________________</td>
</tr>
<tr>
<td># of occasions:</td>
<td># of occasions:</td>
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<tr>
<td>Frequency:</td>
<td>Frequency:</td>
<td>Frequency:</td>
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<td>______________________________</td>
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<tr>
<td>Duration:</td>
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<td>Duration:</td>
</tr>
<tr>
<td>______________________________</td>
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</tr>
<tr>
<td>Location of abuse:</td>
<td>Location of abuse:</td>
<td>Location of abuse:</td>
</tr>
<tr>
<td>□ Victim’s bedroom</td>
<td>□ Victim’s bedroom</td>
<td>□ Victim’s bedroom</td>
</tr>
<tr>
<td>□ Offender’s bedroom</td>
<td>□ Offender’s bedroom</td>
<td>□ Offender’s bedroom</td>
</tr>
<tr>
<td>□ Lounge room</td>
<td>□ Lounge room</td>
<td>□ Lounge room</td>
</tr>
<tr>
<td>□ Bathroom</td>
<td>□ Bathroom</td>
<td>□ Bathroom</td>
</tr>
<tr>
<td>□ Other room in victim’s house</td>
<td>□ Other room in victim’s house</td>
<td>□ Other room in victim’s house</td>
</tr>
<tr>
<td>□ Offender’s house (separate from victim’s)</td>
<td>□ Offender’s house (separate from victim’s)</td>
<td>□ Offender’s house (separate from victim’s)</td>
</tr>
<tr>
<td>□ Car</td>
<td>□ Car</td>
<td>□ Car</td>
</tr>
<tr>
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<td>□ Holiday location</td>
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<tr>
<td>□ Other:__________________________</td>
<td>□ Other: ____________________________</td>
<td>□ Other: ____________________________</td>
</tr>
<tr>
<td>Nature of abusive contact: C A</td>
<td>Nature of abusive contact: C A</td>
<td>Nature of abusive contact: C A</td>
</tr>
<tr>
<td>□ exposing/exhibiting</td>
<td>□ exposing/exhibiting</td>
<td>□ exposing/exhibiting</td>
</tr>
<tr>
<td>□ invitation to sexual touching</td>
<td>□ invitation to sexual touching</td>
<td>□ invitation to sexual touching</td>
</tr>
<tr>
<td>□ touching/fondling</td>
<td>□ touching/fondling</td>
<td>□ touching/fondling</td>
</tr>
<tr>
<td>□ kissing</td>
<td>□ kissing</td>
<td>□ kissing</td>
</tr>
<tr>
<td>□ digital penetration</td>
<td>□ digital penetration</td>
<td>□ digital penetration</td>
</tr>
<tr>
<td>□ oral sex (by offender)</td>
<td>□ oral sex (by offender)</td>
<td>□ oral sex (by offender)</td>
</tr>
<tr>
<td>□ oral sex (forced victim)</td>
<td>□ oral sex (forced victim)</td>
<td>□ oral sex (forced victim)</td>
</tr>
<tr>
<td>□ genital to genital contact, no penetration</td>
<td>□ genital to genital contact, no penetration</td>
<td>□ genital to genital contact, no penetration</td>
</tr>
<tr>
<td>□ vaginal intercourse</td>
<td>□ vaginal intercourse</td>
<td>□ vaginal intercourse</td>
</tr>
<tr>
<td>□ anal intercourse</td>
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<td>□ anal intercourse</td>
</tr>
<tr>
<td>□ other: ______________________________</td>
<td>□ other: ______________________________</td>
<td>□ other: ______________________________</td>
</tr>
<tr>
<td>□ mutual</td>
<td>□ mutual</td>
<td>□ mutual</td>
</tr>
</tbody>
</table>
Appendix J: Results of Inter-rater Reliability Statistical Tests

Table 54: Fleiss free-marginal kappa statistics for the 25 double coded case files

<table>
<thead>
<tr>
<th>Case File Pair</th>
<th>Number of variables</th>
<th>Percent agreement</th>
<th>Fixed-marginal kappa</th>
<th>Free-marginal kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20, V21</td>
<td>35</td>
<td>74.29%</td>
<td>0.484</td>
<td>0.486</td>
</tr>
<tr>
<td>V50, V51</td>
<td>35</td>
<td>77.14%</td>
<td>0.524</td>
<td>0.543</td>
</tr>
<tr>
<td>V46, V47</td>
<td>35</td>
<td>80.00%</td>
<td>0.599</td>
<td>0.600</td>
</tr>
<tr>
<td>V12, V13</td>
<td>67</td>
<td>82.09%</td>
<td>0.638</td>
<td>0.642</td>
</tr>
<tr>
<td>V32, V33</td>
<td>67</td>
<td>83.58%</td>
<td>0.661</td>
<td>0.672</td>
</tr>
<tr>
<td>V4, V5</td>
<td>35</td>
<td>85.71%</td>
<td>0.706</td>
<td>0.714</td>
</tr>
<tr>
<td>V6, V7</td>
<td>35</td>
<td>85.71%</td>
<td>0.699</td>
<td>0.714</td>
</tr>
<tr>
<td>V34, V35</td>
<td>67</td>
<td>86.57%</td>
<td>0.699</td>
<td>0.731</td>
</tr>
<tr>
<td>V38, V39</td>
<td>67</td>
<td>86.57%</td>
<td>0.715</td>
<td>0.731</td>
</tr>
<tr>
<td>V44, V45</td>
<td>67</td>
<td>86.57%</td>
<td>0.699</td>
<td>0.731</td>
</tr>
<tr>
<td>V28, V29</td>
<td>67</td>
<td>88.06%</td>
<td>0.749</td>
<td>0.761</td>
</tr>
<tr>
<td>V8, V9</td>
<td>35</td>
<td>88.57%</td>
<td>0.767</td>
<td>0.771</td>
</tr>
<tr>
<td>V14, V15</td>
<td>35</td>
<td>88.57%</td>
<td>0.755</td>
<td>0.771</td>
</tr>
<tr>
<td>V48, V49</td>
<td>35</td>
<td>88.57%</td>
<td>0.762</td>
<td>0.771</td>
</tr>
<tr>
<td>V2, V3</td>
<td>67</td>
<td>89.55%</td>
<td>0.754</td>
<td>0.759</td>
</tr>
<tr>
<td>V10, V11</td>
<td>67</td>
<td>89.55%</td>
<td>0.766</td>
<td>0.761</td>
</tr>
<tr>
<td>V24, V25</td>
<td>67</td>
<td>89.55%</td>
<td>0.786</td>
<td>0.791</td>
</tr>
<tr>
<td>V40, V41</td>
<td>67</td>
<td>89.55%</td>
<td>0.760</td>
<td>0.791</td>
</tr>
<tr>
<td>V18, V19</td>
<td>35</td>
<td>91.43%</td>
<td>0.823</td>
<td>0.829</td>
</tr>
<tr>
<td>V42, V43</td>
<td>35</td>
<td>91.43%</td>
<td>0.819</td>
<td>0.826</td>
</tr>
<tr>
<td>V22, V23</td>
<td>35</td>
<td>94.29%</td>
<td>0.883</td>
<td>0.886</td>
</tr>
<tr>
<td>V26, V27</td>
<td>35</td>
<td>94.29%</td>
<td>0.885</td>
<td>0.886</td>
</tr>
<tr>
<td>V30, V31</td>
<td>35</td>
<td>94.29%</td>
<td>0.873</td>
<td>0.886</td>
</tr>
<tr>
<td>V36, V37</td>
<td>67</td>
<td>95.52%</td>
<td>0.895</td>
<td>0.910</td>
</tr>
<tr>
<td>V16, V17</td>
<td>35</td>
<td>97.14%</td>
<td>0.938</td>
<td>0.943</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>87.94%</strong></td>
<td><strong>0.745</strong></td>
<td><strong>0.756</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: The cases with 67 variables were the accepted offenders who had more variables to code, than the declined offenders (35 variables)
Table 55: Intraclass correlation coefficients and 95% confidence interval, for the 25 double coded case files

<table>
<thead>
<tr>
<th>Case File Pair</th>
<th>Number of variables</th>
<th>Intraclass correlation coefficient</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>V6,V7</td>
<td>47</td>
<td>0.552</td>
<td>0.319 - 0.722</td>
</tr>
<tr>
<td>V32,V33</td>
<td>51</td>
<td>0.613</td>
<td>0.409 - 0.758</td>
</tr>
<tr>
<td>V30,V31</td>
<td>47</td>
<td>0.618</td>
<td>0.406 - 0.767</td>
</tr>
<tr>
<td>V36,V37</td>
<td>51</td>
<td>0.660</td>
<td>0.473 - 0.790</td>
</tr>
<tr>
<td>V34,V35</td>
<td>51</td>
<td>0.723</td>
<td>0.561 - 0.831</td>
</tr>
<tr>
<td>V14,V15</td>
<td>47</td>
<td>0.740</td>
<td>0.579 - 0.846</td>
</tr>
<tr>
<td>V12,V13</td>
<td>51</td>
<td>0.770</td>
<td>0.630 - 0.862</td>
</tr>
<tr>
<td>V24,V25</td>
<td>51</td>
<td>0.802</td>
<td>0.678 - 0.882</td>
</tr>
<tr>
<td>V44,V45</td>
<td>51</td>
<td>0.813</td>
<td>0.695 - 0.889</td>
</tr>
<tr>
<td>V42,V43</td>
<td>47</td>
<td>0.828</td>
<td>0.712 - 0.900</td>
</tr>
<tr>
<td>V10,V11</td>
<td>51</td>
<td>0.830</td>
<td>0.721 - 0.899</td>
</tr>
<tr>
<td>V22,V23</td>
<td>47</td>
<td>0.847</td>
<td>0.742 - 0.912</td>
</tr>
<tr>
<td>V26,V27</td>
<td>47</td>
<td>0.866</td>
<td>0.772 - 0.923</td>
</tr>
<tr>
<td>V4,V5</td>
<td>47</td>
<td>0.875</td>
<td>0.788 - 0.928</td>
</tr>
<tr>
<td>V48,V49</td>
<td>47</td>
<td>0.882</td>
<td>0.799 - 0.933</td>
</tr>
<tr>
<td>V2,V3</td>
<td>51</td>
<td>0.890</td>
<td>0.815 - 0.935</td>
</tr>
<tr>
<td>V46,V47</td>
<td>47</td>
<td>0.917</td>
<td>0.856 - 0.953</td>
</tr>
<tr>
<td>V38,V39</td>
<td>51</td>
<td>0.924</td>
<td>0.871 - 0.986</td>
</tr>
<tr>
<td>V50,V51</td>
<td>47</td>
<td>0.933</td>
<td>0.883 - 0.962</td>
</tr>
<tr>
<td>V20,V21</td>
<td>47</td>
<td>0.952</td>
<td>0.916 - 0.973</td>
</tr>
<tr>
<td>V40,V41</td>
<td>51</td>
<td>0.958</td>
<td>0.928 - 0.976</td>
</tr>
<tr>
<td>V8,V9</td>
<td>47</td>
<td>0.965</td>
<td>0.938 - 0.980</td>
</tr>
<tr>
<td>V16,V17</td>
<td>47</td>
<td>0.969</td>
<td>0.945 - 0.983</td>
</tr>
<tr>
<td>V18,V19</td>
<td>47</td>
<td>0.983</td>
<td>0.970 - 0.990</td>
</tr>
<tr>
<td>V28,V29</td>
<td>51</td>
<td>0.983</td>
<td>0.971 - 0.990</td>
</tr>
</tbody>
</table>

Average ICC **0.836**

Note: The cases with 51 variables were the accepted offenders who had more variables to code, than the declined offenders (47 variables)
Appendix K: Abstracts of Research Theses Related to the Evaluation Project

One Honours research thesis in Psychology and seven M Psychol (Forensic) theses were completed using the evaluation sample data gathered in the course of this evaluation project. The thesis abstracts are listed below. Full copies of each thesis are included as separate appendices in this document.


This study examined the predictive validity of actuarial risk assessment instruments the Static-99 (Hanson & Thornton, 1999) and the SONAR (Hanson & Harris, 2001) for sexual, violent, and general recidivism in a sample of 208 male offenders convicted of intrafamilial sexual offences. Neither stand alone instrument’s total scores, nor combined scores from the two tools were significant predictors of sexual or violent type of recidivism as measured by ROC curve, correlation and Cox proportional-hazard analyses. Static-99 scores were modestly predictive of general recidivism. The only individual risk factor which significantly predicted sexual recidivism was prior non-contact sexual offences. The factors most associated with violent recidivism were prior violent and criminal convictions, male victims, and sexual and general self-regulation problems. Factors which were predictive of general recidivism included younger age, prior convictions and sexual and general self-regulation problems. These results indicate that neither the Static-99 nor the SONAR is suitable in its current form for risk assessment of intrafamilial sex offenders in this programme. Implications for actuarial risk assessment of intrafamilial sex offenders are discussed and recommendations made for a new risk assessment instrument developed specially for intrafamilial sex offenders.


Acceptance of intrafamilial child sex offenders into a treatment programme generally requires that the offender admit and accept responsibility for the crimes with which he was charged. Once this level of disclosure has been reached, it is rare for him to be challenged regarding other offences that he may have committed. However, anecdotal clinical reports describe these offenders as disclosing a higher level of abuse than that provided by the victim. This study built on the limited empirical research on this topic. Participants were 67 males accepted into treatment at the NSW Pre-Trial Diversion of Offenders Programme (Cedar Cottage) between 1989 and 2003. 43 participants successfully completed the treatment programme while 24 participants breached or withdrew from the programme. Twenty-two percent of participants disclosed victims beyond the individual for whom they were referred to the programme. All offenders revealed significantly more details regarding their offending behaviour, regarding victim age when offending began, the duration and frequency of offending, the number of locations where abuse occurred, and the range and intrusiveness of abusive acts committed. Participants who completed the programme did not disclose more than those who failed to complete the programme. The level of disclosure provided did not impact on recidivism. These results suggest that the extent and nature of abuse by
intrafamilial child sex offenders are underestimated in the early stages of detection, and that refusal of offenders into treatment programmes based on denial and minimisation is a practice that needs to be reviewed.


Objective: The objective of the current study was to examine post treatment reunification in families where incest has been perpetrated by a father figure. Reunified and non-reunified families were compared on potential predictors of reunification and measures of recidivism.

Method: The current sample included 73 men who were accepted into a Pre-trial Diversion Program for incest offenders. All of these men were biological or step-fathers who had sexually abused one or more of their children. In the sample, 47 men successfully completed treatment and the remaining 26 men breached their treatment conditions and were suspended from the program. Initial data was gathered from treatment files of the men. This was paired with re-offence data from the Police and the Bureau of Crime Statistics and Research.

Results: Results revealed that when the child disclosed directly to the mother, families were more likely to separate. Age of the child at disclosure and non-offending parent treatment did not predict reunification. When reunification views at both the beginning and end of treatment were taken into account, only the non-offending parents view was predictive of reunification. Offender’s levels of commitment to treatment and posttreatment reunification status had no impact at all on recidivism. Conclusions: Familial support had no effect on recidivism for incest offenders in the current sample. Non-offending parents play a key role in the ultimate decision to reunify. Treatment and policy should aim to educate parents of the potential risks associated with reunification.


Treatment attrition from sex offender treatment programs is high. Given the elevated risk of recidivism for treatment dropouts, there has been an increase in interest within psychological literature in the development of models that aid in predicting treatment attrition so that early intervention can occur. However, there has been considerable discrepancy in what factors are considered to classify sexual offenders as being high risk of attrition. One explanation for this discrepancy is the heterogeneity of sexual offender types. Intrafamilial child sex offenders differ in many respects to other sexual offenders and thus need to be considered separately. The current study aimed at identifying whether intrafamilial child sexual offenders in a community based treatment program who failed to complete treatment (“noncompleters”) were at a higher risk of reoffending than offenders who completed treatment (“completers”) or those who never received treatment at all (“declined”). Moreover variables that fall under the Risk, Need and Responsivity principles were examined to determine if they could reliably predict treatment attrition. Results indicated that treatment noncompleters reoffended at a comparable rate to treatment completers and offenders who were declined treatment. Logistic regression analyses revealed that one demographic and two responsivity variables reliably predicted whether offenders completed treatment. These findings are discussed with reference to current psychological theories and research, and practical implications, limitations, and suggestions for future research are provided.

Reunification where intrafamilial abuse has occurred is a posttreatment goal for many families. Given the acknowledged difficulties in studying intrafamilial child abusers and their families, there is a paucity of research on factors that affect the ultimate decision to reunify. This study examined the influence of length of relationship between the offender and nonoffending parent, relationship between offender and victim, age of victim at time of abuse, age of victim at time of disclosure, impact of treatment, and additional disclosures of abuse on interest in reunification by the offender, nonoffending parent and victim following treatment of the offender. The relationship between interest and attempted reunification was also examined. Participants were 73 males accepted for treatment at the New South Wales Pre-Trial Diversion of Offenders Program between 1989 and 2003, and their families. For victims, the additional disclosure of abuse details by the offender during a face-up significantly decreased interest in reunification. For mothers, the disclosure of additional offences/victims significantly decreased interest in reunification. Interest by mothers in reunification was lower when the victim was younger at the time of abuse. Overall, interest difference scores before and after treatment suggested that treatment had no significant impact on interest in reunification by any of the parties. Victims consistently reported low levels of interest in reunification at all stages of treatment. The interest of the offender, and in particular, the nonoffending parent, in reunification following treatment were determining factors in family attempts to reunify. The limitations of the study and suggestions for further research are discussed.


Sexual offences against children are a significant societal, legal and community problem and more information is needed to better understand which factors are important in sexual recidivism. Sexual offending attributions and the nature of the victim-offender relationship were assessed as predictors of sexual recidivism in a sample of 214 adult male intrafamilial offenders attending a pretrial diversion treatment program. Offender attributions about their sexually abusive conduct were classified as internal, stable and uncontrollable or external, unstable and controllable. Offenders who made internal, stable and uncontrollable attributions were more likely to recidivate than offenders who made external, unstable and uncontrollable causal attributions for their conduct, but these differences were not statistically significant. Nonbiological parents were more likely to make internal, stable and uncontrollable attributions than biological parents and more likely to sexually recidivate. The results suggested that causal attributions which were internal, stable and uncontrollable were more difficult to modify, and appeared to help maintain the offending behaviour. Both the attribution model and a competing behavioural model were equally able to account for observed recidivism rates in the sample of intrafamilial offenders. Practical implications and suggestions for future research are discussed.

Following conviction for a sexual offence, many offenders persist in denying the extent of their involvement in the offence or that it even took place. Previous research suggested that across all sexual offenders, denial was unrelated to sexual or violent recidivism. Research specifically on intrafamilial child sexual offenders revealed that denial was associated with increased sexual recidivism. The current study explored the stage at which denial is measured; the effect of denial on treatment; and the heterogeneity of the sexual offender sample. The current study involved 214 intrafamilial child sexual offenders assessed for treatment at the NSW Pre-Trial Diversion of Offenders Program (Cedar Cottage) between 1989 and 2003. Four levels of pretreatment denial were distinguished. Although increased levels of denial significantly diminished the likelihood of being accepted into the treatment program, pretreatment denial was unrelated to recidivism rates. Exploration of demographic, offence and treatment variables raised concerns about inappropriate limitations of treatment options offered to offenders who initially deny their offence. A broader, more fluid definition of denial is recommended to inform treatment amenability. Denial assessment should serve as a treatment tool rather than an exclusion criterion for program acceptance.


Objective: Investigate factors that influence to whom children disclose intrafamilial child sexual abuse, and how children’s choice of disclosure recipients influences the reporting of child sexual abuse to appropriate authorities.

Method: Data were extracted from clinical files of 248 victims of intrafamilial child sex offenders referred for treatment to the NSW Pre-Trial Diversion of Offenders Program (Cedar Cottage). Seven variables proposed to influence to whom children disclose, and the impact of this choice on reporting of sexual abuse were coded: children’s age at abuse onset and disclosure, severity and duration of abuse, the victim’s relationship to the perpetrator, the perpetrator’s residence, and whether the abuse was occurring when disclosure was made.

Results: Victim age at abuse onset and disclosure, and the duration of the abuse, contributed significantly to a child’s choice of a disclosure recipient. The person to whom children disclosed abuse significantly influenced whether child sexual abuse was reported by the disclosure recipient, the agency where the abuse was reported, and the time between disclosure and reporting. Conclusions: Children’s age and the duration of abuse are critical variables in the disclosure and reporting of child sexual abuse. The influence of these variables on children’s decisions about the person to whom to disclose abuse has significant practical implications for the likelihood that the abuse will be officially reported to investigative authorities.

Actuarial risk assessment for recidivism in incest offenders:

Predictive validity of the Static-99 and the SONAR.

By Thea Gumbert

Supervisor: Jane Goodman-Delahunty
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Abstract

This study examined the predictive validity of actuarial risk assessment instruments the Static-99 (Hanson & Thornton, 1999) and the SONAR (Hanson & Harris, 2001) for sexual, violent, and general recidivism in a sample of 207 male offenders convicted of intra-familial sexual offences. Neither stand alone instrument’s total scores, nor combined scores from the two tools were significant predictors of all or sexual type of recidivism as measured by Cox proportional-hazard analyses. SONAR total scores were predictive only of violent recidivism, whilst Static-99 scores and combined scores were predictive of both violent and non-sexual non-violent recidivism. No total or combined scores were predictive of all or sexual recidivism. The individual risk factors which predicted all recidivism were sexual and general self-regulation problems, prior non-sexual violence and prior sentencing dates. The only individual risk factors which significantly predicted sexual recidivism were age under 25 and prior non-contact sexual offences. The individual risk factors associated with violent recidivism were younger age, negative social balance, prior violent and criminal convictions, sexual and general self-regulation problems and increased victim access. Factors which were predictive of non-sexual non-violent recidivism included younger age, prior convictions and sexual and general self-regulation problems. These results indicate that neither the Static-99 nor the SONAR is suitable in its current form for risk assessment of incest offenders. Implications of actuarial risk assessment of incest offenders are discussed and recommendations made for a new risk assessment instrument developed specifically for incest offenders.
Introduction

Despite extensive research exploring actuarial recidivism risk assessment for sexual offenders, including subtypes such as adult rapists and child molesters (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2005), little research has focused exclusively on incest offenders. The accuracy of actuarial risk assessment tools such as the Static-99 (Hanson & Thornon, 1999) and the Sexual Offender Need Assessment Rating (SONAR; Hanson & Harris, 2001) regarding incest is therefore unknown. Some researchers have observed significant differences between incest offenders and other types of sexual offenders such as adult rapists or extra-familial child molesters, including a lesser tendency to use violence and force whilst offending, less proclivity to have a history of criminal convictions, and a higher proclivity to live with an intimate partner (Herman, 2000; Johnson, 2007). These differences imply that risk factors may apply for recidivism in incest offenders which are not congruent with existing models of sex offender risk assessment. In summation, there is little consensus amongst sex offender researchers regarding risk and protective factors for recidivism in incest offenders, and there is little, if any, Australian research addressing these questions.

“Incest” is differentially defined for different purposes. Legally, sexual relations between parents and children, grandparents, brothers and sisters, aunts, uncles, nieces, and nephews, are prohibited under Australian law. Most research deals explicitly with incidents of adults incestuously abusing children, as this form of incest seems to be more widespread and is more serious a problem than consensual sex between related adults (Herman, 2000).

Recidivism can be defined either as an offender’s return to any kind of crime, or to a specific type of crime, such as sexual, violent, or general (non-sexual, non-violent) recidivism. These three types of recidivism are of interest in this study, based on previous
research indicating that sex offenders are more likely to recidivate to non-sexual, non-violent crime than to sexual or violent crime (Gelb, 2007; Wortley & Smallbone, 2006).

Actuarial recidivism risk assessment: The Static-99 and SONAR

Actuarial risk assessment tools aid forensic practitioners in determining which offenders are most likely to recidivate. Two commonly used instruments are the Static-99 (Hanson and Thornton, 1999), and the Sex Offender Need Assessment Rating (SONAR: Hanson & Harris, 2001), both of which primarily predict sexual and violent recidivism, and can also be used to predict general recidivism (Hanson & Harris, 2001). These two tools differ substantively as the Static-99 is comprised of static risk factors, whilst the SONAR is comprised of dynamic risk factors.

Static risk factors are those which are fixed and unchangeable across time or treatment, such as previous criminal offences, or a history of child abuse. The theory underpinning reliance on these factors to assess future risk is that the best tool for predicting future behaviour and patterns of offending is the examination of past behaviour and patterns of offending (Hanson & Thornton, 1999). The Static-99 is comprised of the following ten static factors related to the offender; (1) age; (2) history of living with an intimate partner; (3) prior violent, non-sexual convictions; (4) prior non-sexual violence; (5) prior sex offences; (6) prior sentencing dates; (7) non-contact sex offences; (8) unrelated victims; (9) stranger victims; and (10) male victims.

The SONAR was developed to examine dynamic risk factors, or risk factors which are able to change across time, such as compliance with a treatment program, or level of insight into criminal behaviour. Dynamic factors are further classified into the categories of stable-dynamic and acute-dynamic risk factors. Stable factors refer to enduring traits or characteristics (e.g., intimacy deficits), whilst acute (or “triggering”) factors are shorter-term
states (e.g., intoxication, anger, or distress) which tend to heighten the risk of re-offending during that state (Hanson, 2006).

The theoretical premise for the inclusion of dynamic risk factors in risk assessment instruments is that they are more sensitive, as they can provide different assessments across time and treatment. For example, an offender evaluated with the Static-99 would be rated at the same level of recidivism risk both before and after compliance with a treatment program, but if the same offender were assessed with an actuarial instrument including dynamic factors at the beginning and at the end of treatment, his assessed level of risk may change in accordance with his more recent behaviour and mental state. The SONAR contains five stable-dynamic risk factors, and four acute-dynamic risk factors. The stable factors are; (1) intimacy deficits; (2) social influences; (3) attitudes; (4) sexual self-regulation, and (5) general self-regulation. The acute factors are; (1) substance abuse; (2) negative mood; (3) anger/hostility, and (4) opportunities for victim access.

Some research has reported the Static-99 to have high predictive validity for sexual, violent and general (non-sexual, non-violent) recidivism across different groups of sexual offenders (e.g., Bartosh, Garby, Lewis & Gray, 2003; Stadtland, Hollweg, Kleindienst, Dietl, Reich & Nedophil, 2005). A study which used various instruments to assess risk of several different types of sex offenders, including a sample of 37 incest offenders, found the Static-99 significantly predict violent, sexual and general recidivism in both extra-familial and incest offenders, reporting extremely high ROC (Receiver Operating Characteristic) values for the Static-99 as a predictor of all types of recidivism (Bartosh et al., 2003). ROC analyses involve the relative weighting of false positive and false negative outcomes in diagnostic tests, and are commonly used in recidivism studies, where a result of .7 is considered a moderately strong correlation between assessed and actual risk levels, and .5 is considered no better than chance.
Bartosh et al. (2003) reported that the ROC value for the Static-99 as a predictor of sexual recidivism was higher for incest offenders (.735) than for rapists (.714) and extra-familial child molesters (.647). The study also reported substantial ROC values for the Static-99 as a predictor of violent recidivism in incest offenders (.919). However, the Static-99 was reported to be a less accurate, though still significant, predictor of any recidivism offences in incest offenders (ROC=.688) than in extra-familial child molesters (.724). To date, these results have not been either replicated or refuted, and therefore they must be interpreted with care, in light of the small sample of offenders used (n=37). Also, Bartosh et al. (2003) did not investigate the relationship between individual risk factors of the Static-99 and recidivism, and thus were unable to report which items of the Static-99 were the most significant predictors of recidivism.

Other research has reported the Static-99 to be inaccurate or non-significant in terms of predictive validity for recidivism risk assessment. For instance, one study of extra-familial sex offenders found the Static-99 to have “relatively weak” relationships with any type of recidivism, with results obtaining marginal significance (Caperton, 2006). Similarly, Hanson and Harris (2003) reported that the ROC value for total Static-99 scores as a predictor of sexual recidivism in sex offenders was only .62. More research is needed to clarify the inconsistent results in different studies, in relation to the predictive validity of the Static-99, and to determine if this tool can be reliably used to assess recidivism risk in incest offenders.

The SONAR has been demonstrated as useful in assessing recidivism risk for offenders who are community-based rather than institutionalized, (Gelb, 2007) as it contains items related to living habits which are not relevant to incarcerated offenders (e.g., victim access). However, there has been little research regarding its reliability and validity, beyond the initial studies by Hanson and Harris, (2001; 2001b) which examined 409 non-incestuous sexual offenders such as rapists and child-molesters. These studies reported the SONAR to
have moderate predictive validity for sexual recidivism, which was operationalised as a new offence report, charge or conviction, whilst violent, non-sexual and general recidivism were not examined. For example, Hanson and Harris (2001b) found a correlation of $r = .43$ between SONAR total scores and recidivism, and mean SONAR total scores of 8.0 for recidivists, and 5.3 for non-recidivists (where possible scores range from -3 to 14, where higher scores indicate higher risk).

The SONAR can be used in conjunction with the Static-99. Hanson and Harris (2003) found a correlation of $r = .14$ between SONAR and Static-99 scores. Although significant, this is a relatively small correlation, indicating that there may not always be a high or even significant degree of correspondence between SONAR and Static-99 scores, as they are based on different risk factors.

Characteristics of incest offenders

Incest offenders appear to differ from other sexual offender populations, such as non-familial child molesters and adult rapists in several respects. Herman, a clinical psychiatrist in the USA, interviewed a sample of 42 adult female incest survivors in the USA, and noted that “no one has been able to come up with a psychological ‘profile’ that might identify incest offenders, because they look too normal,” (Herman, 2000, p.229). This and other research have found that incest offenders are often successful or at least competent in terms of employment and education, married or in de facto relationships, and often have no criminal history (Johnson, 2007). By comparison, two Australian psychologists (Smallbone & Wortley, 2000) who studied 182 convicted child sex offenders, including 79 incest offenders, concluded in a later report that “for many…the problems seems to be less some special motivation to abuse children than a more general problem involving the failure to inhibit
urges and impulses… these offenders may be better portrayed as ‘opportunity takers’ than ‘sexual deviants’,” (Wortley & Smallbone, 2006, p.12).

Further research is necessary to more clearly identify the typical characteristics of incest offenders, particularly in light of the fact that many existing theories about incest offenders are not based upon empirical research. For example, Herman’s (2000) findings are based on clinical interviews with 42 adult victims of incest, with no direct study of offenders, whilst those of Johnson (2007), a counseling and forensic psychologist, are based only upon clinical observation of incest offenders. These methods do not allow us to ascertain whether incest offenders significantly tend towards these observed characteristics, or how these tendencies may compare with those of other sexual offender sub-types.

Comparing incest with other types of sexual offending

The fact that certain aspects of incest offending differ substantially from other types of sexual offending presents problems for risk assessment using tools which were designed for use with extra-familial sex offenders. Salient differences between incest offenders and other types of sexual offenders that have implications for using these test instruments fall into three categories, regarding a) the relationship between the victim and offender; b) the tendency to use violence or force; and c) historical and psychosocial factors. These are specified below.

The victim-offender relationship
The incest offender usually assumes a parental or family authority role, and resides with his victim\(^1\). Child molesters and adult rapists usually know their victims at least to some extent, but are (with the exception of spousal rape) unlikely to live with them, or to have any formal authority over them. The formal relationship and authority between parent and child, and virtually unlimited access to the victim, furnishes the incest offender with the opportunity to offend repeatedly, over a long period of time, and in the seclusion of a home environment, in marked contrast to other types of sexual offenders who may have to “cruise” for a series of new victims, and commit assaults in riskier environments (Herman, 2000; Johnson, 2007). In the sample of Herman (2000), incest offenders abused their victims for a mean duration of 3.8 years.

By definition, the close relationship between the incest offender and his victim limits the usefulness of the Static-99 items; “unrelated victims” and “stranger victims” in assessing recidivism risk assessment for incest offenders.

Violence and force

Some researchers have proposed that incest offenders, unlike child molesters and adult rapists, are unlikely to use overt force in the act of offending (Herman, 2000; Johnson, 2007). The parental authority exercised by the offender, coupled with sophisticated tactics of coercion and “grooming” of the victim, can often remove the need to use overt force during a sexual assault. There is, however, no empirical research to confirm or refute this observation. The findings of Herman (2000) and Johnson (2007) are largely drawn from clinical observation of incest offenders, and from small or undeclared sample sizes.

\(^1\) The masculine pronoun is used with reference to incest offenders throughout this article. This is not to suggest that incest offending is the exclusive domain of males, but refers to the greater likelihood that incest offenders are male than female (Herman, 2000; Gelb, 2007).
If incest offenders are unlikely to apply violence or force in the commission of their offences, then the Static-99 item “index non-sexual violence” would be of limited usefulness in assessing recidivism risk for incest offenders, as this item concerns violent charges (such as assault) accompanying the incest offence.

Historical and psychosocial factors

By definition, incest offenders, unlike other sexual offender-types, are extremely likely to have lived for a period of time in an intimate, marriage-like relationship. This renders the Static-99 item “history of living with an intimate partner” relatively useless as a protective factor in recidivism risk assessment in incest offenders. No known empirical studies have examined the likelihood that incest offenders have lived in an intimate relationship, although Herman (2000) reports that all of the offenders who had incestuously abused her sample of 42 female victims had been married.

Researchers have yet to reach consensus regarding the likelihood that incest offenders will have a history of psychological disorders. Incest offenders are more likely than adult rapists to suffer from depression, anxiety, personality disorders, attachment disorders, and paraphilias, as observed by Johnson (2007). However, other researchers reported little evidence of mental illness in incest offenders, aside from sexual obsession and sexual compulsivity (Herman, 2000; Gelb, 2007). There is relative consensus, however, that incest offenders, like child molesters, show a tendency towards drug and/or alcohol abuse, and that they tend to blame intoxication for their abusive behaviour (Herman, 2000; Gelb, 2007; Johnson, 2007).

The following table depicts some of the contradictory and contentious results which have emerged from investigations of risk factors for incest offending.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Incest offenders</th>
<th>Child Molesters</th>
<th>Rapists</th>
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<tbody>
<tr>
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<td>Herman 2000</td>
<td>Johnson 2007</td>
<td>Gelb 2007</td>
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<td>Characteristics of incest offenders, child molesters and adult rapists as observed by three different researchers. Y = characteristic substantially observed, N = not substantially observed, 0 = not addressed.</td>
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Table 1: Characteristics of incest offenders, child molesters and adult rapists as observed by three different researchers. Y = characteristic substantially observed, N = not substantially observed, 0 = not addressed.

Incest and recidivism

Research suggests that child molesters and rapists are more likely to recidivate to general than to sexual crime (Hanson & Bussiere, 1998; Gelb, 2007). Rapists are more likely to recidivate than are child molesters, with respective rates of 18.9% and 12.7% for sexual recidivism, and 46.2% to 36.9% for any recidivism (Hanson & Bussiere, 1998). A meta-analysis of recidivism studies indicated that sex offenders sexually recidivate at levels of 10-15% over five years (Hanson & Morton-Bourgon, 2005).
Incest offenders have been found to be at higher risk of general (non-sexual non-violent) than sexual recidivism, although either at lower rates or with lower rates of detection than other types of sexual offenders (Hanson, Steffy & Gaulthier, 1993; Gelb, 2007). Gelb (2007) reported rates of sexual recidivism in incest offenders of around 6% over five years, and 13% after 15 years. A US study of 251 incest offenders who had never been convicted of other sexual offences, found that 6.4% recidivated to sexual offending, 12.4% to violent offending, and 26.7% to other criminal offences over a twelve-year follow-up period (Firestone, Bradford, McCoy, Greenberg, Larose & Curry, 1999). Of the 37 incest offenders included in a study by Bartosh et al. (2003), 11% recidivated to sexual offending, 19% to violent offending, and 22% to general offending.

An Australian study of 182 incarcerated males convicted of various sexual offences found that 35% of intra-familial sex offenders recidivated to property crime, and only 10% to sexual offences in a five-year follow up period (Smallbone & Wortley, 2000). Comparable rates of recidivism are expected to be found in the current sample of incest offenders.

Incest and actuarial risk assessment

Incest offending, as well as tendency to recidivate, appear to differ significantly from other types of sexual offending, warranting investigation as to whether current risk assessment tools adequately predict recidivism in incest offenders. No known study exists in which the Static-99 or SONAR were used to assess risk of recidivism in a core sample of incest offenders. Nor has any previous study specifically addressed the reliability of these measures in such a sample. Whilst some of the items included on each assessment measure appear to have a reliable basis for inclusion in these tools (e.g., sexual self-regulation), others may not be accurate predictors of recidivism in incest offenders (e.g., stranger victims). Therefore, there is an urgent need to assess the suitability of these tools and items for such a
sample. The items included in the Static-99 and SONAR are reviewed in more detail in the following section, with reference to their use in predicting recidivism in incest offenders as opposed to other sexual offenders. The items from the two instruments are grouped in terms of potentially high, questionable and low validity for predicting recidivism in incest offenders.

Items with high validity for assessing recidivism in incest offenders

Six items appear to have high validity for recidivism risk assessment in incest offenders.

Male victims (Static-99)

A meta-analysis of recidivism studies found a small but significant correlation between sexual recidivism and offences against male victims ($r=0.11$; Hanson & Bussiere, 1998). The same study reported strong correlations between offences against male victims, and a number of measures of sexual deviance, indicating that sexual offences against males are an index of sexual deviance and may reflect increased opportunism (Hanson & Bussiere, 1998). Recent research found that child molesters with male victims were at 23% risk to sexually recidivate after five years, whilst child molesters with female victims only were at 9% risk (Harris & Hanson, 2004). The proclivity for male victims is hypothesised to be a reliable predictor of sexual recidivism in incest offenders, as in other sexual offender populations, although it appears unlikely to bear any significant relationship to violent or non-sexual non-violent recidivism.

Social balance (SONAR)

Sexual recidivism is reported to be more likely in offenders whose peers or social supporters have higher tolerance for sexual offending, are themselves sexual offenders,
support the offender’s denial or minimization of offence-related behaviours, or facilitate victim access (Hanson & Harris, 2001). The authors of the SONAR reported a correlation of $r=.30$ between sexual recidivism and negative social influences (Hanson & Harris, 2001). A higher number of criminal associates has been shown to be a significant predictor of general criminal recidivism in criminal samples (Hanson & Harris, 2003). However, a lack of previous research with sexual offenders in general and incest offenders in particular urges further investigation of this item as a predictor of all types of recidivism.

**Sexual self-regulation (SONAR)**

Sexual offenders are likely to have higher than usual degrees of what may be termed sexual entitlement; that is, they perceive themselves as having stronger than normal sexual urges, and may feel entitled to act out their sexual desires (Hanson & Harris, 2003). Furthermore, sexual offenders are likely to engage in deviant sexual fantasies as a coping mechanism during and after stressful events (Proulx, McKibben & Lusignan, 1996). Offenders with a higher tendency to employ these mechanisms would be considered at a higher risk of sexual recidivism.

One meta-analysis reported that sexual self-regulation problems, (including sexual preoccupations, a subscale of the SONAR), were amongst the most reliable of predictors of sexual ($d=.30$) and violent ($d=.19$), but not of non-sexual non-violent recidivism ($d=.04$, Hanson & Morton-Bourgon, 2005). Other research reported a correlation of $r=.31$ between sexual self-regulation problems and sexual recidivism (Hanson & Harris, 2003). There is little reason to believe that sexual self-regulation factors are of any less predictive validity for sexual and violent recidivism in a sample of incest offenders.
General self-regulation (SONAR)

Poor self-control and high impulsivity have been found to be good predictors of all types of recidivism across different samples of criminal offenders, including sex offenders, as reflected by the inclusion of these items in well-established scales such as the Hare Psychopathy Checklist-Revised (Hare, 1991). Self-regulation problems are so common amongst criminal offenders that Gottfredson and Hirshi (1990, in Hanson & Harris, 2003) have proposed that low impulse-control is an essential element of criminal behaviour.

As previously noted, some researchers identify incest offenders as opportunistic, more easily identified by low degrees of self-control than high degrees of sexual deviance (Wortley & Smallbone, 2006). A meta-analysis of recidivism research has lent support to the link between low self-regulation and a heightened risk of recidivism, finding that general self-regulation problems were a substantial predictor of any recidivism in sex offenders \(d=.75;\) Hanson & Morton-Bourgon, 2005). Recent research revealed a correlation of \(r=.41\) between general self-regulation problems and sexual recidivism (Hanson & Harris, 2003). Furthermore, a study by Stinson, Becker and Sales (2008) found self-regulation problems (measured by affective instability and mood dysregulation) to be a causal predictor of both sexual deviance and antisocial behaviour.

The authors of the SONAR noted that “self-management skills are required in order to conform to the demands of treatment and community supervision, and to sustain long-term life changes,” (Hanson & Harris, 2003, p.5). For this reason, general-self regulation measures should be of good predictive value in risk assessment for all categories of recidivism in incest offenders.
Increased drug/alcohol abuse (SONAR)

A study of sexual offenders found a correlation of $r=0.19$ between increased alcohol/substance abuse and sexual recidivism (Hanson & Harris, 2003). In a sample of incest offenders, Firestone et al. (1999) found that those who recidivated to sexual or violent crime, rated themselves significantly higher on the Michigan Alcohol Screening Test than did the offenders who did not (mean scores respectively were, 25.8 vs. 9.6 for sexual recidivism, and 19.5 vs. 9.2 for violent recidivism). The same study reported that offenders who recidivated to general crimes were more almost twice as likely to report a history of drug abuse as those who did not (37.5% vs. 18.0%). Herman (2000) and Johnson (2007) both noted a high tendency for incest offenders to have substance abuse problems, and to blame their offending behavior upon intoxication with alcohol or drugs. However, further empirical research is required to examine the link between increased substance abuse and all types of recidivism, and to confirm, or otherwise, the findings of Firestone et al. (1999) in an Australian sample.

Negative mood (SONAR)

Some evidence suggested that sexual offending, including re-offending, may be triggered by poor coping in response to stressors. As reported in a review of current sexual offender research, “many sexual offenders report loneliness, loss of work, or anger as pre-offence stressors, and they often respond by increasing their use of alcohol or drugs, or attempting to use sex as a way of alleviating feelings of loneliness” (Serran & Marshall, 2006, p.109). Although no available research specifically addresses this question in relation to incest offenders, Proulx et al. (1996) found that negative mood states and interpersonal conflicts increase the frequency of deviant sexual fantasies and associated masturbation in a sample of child molesters and rapists, and Hanson and Harris (2003) found a correlation of
between increased negative mood and sexual re-offending in a sample of sexual offenders. These findings suggest that increased negative mood may be of substantial use in risk assessment for sexual-reoffending in incest offenders. It is uncertain, however, if this item will be useful as a predictor of violent or non-sexual non-violent recidivism.

Items with questionable validity for assessing recidivism in incest offenders

Six items of the Static-99 and four items of the SONAR appear questionable as predictors of recidivism in incest offenders, as they were designed for use with other types of sexual offenders. These are detailed below.

Offender age (Static-99)

The first item of the Static-99 is based upon decades of research indicating that most crime is committed by young persons, aged between 16 and 18 years, and that the tendency to commit crime gradually decreases with age. However, incest offenders tend to be older than other types of sexual offenders. For instance, the average age at sentencing of convicted incest offenders in Victoria between 2001 and 2006 was 47 years and 4 months, with no offenders under 25 years of age, and 8% over the age of 60 (Gelb, 2007).

In non-incestuous sex offenders, younger age is a risk factor for sexual, violent and general recidivism, whilst advanced age is a protective factor (Hanson & Morton-Bourgon, 2004; Gelb, 2007). Hanson (2001) claimed that the rate of incest recidivism peaked between the ages of 16 and 24 years and decreased steadily with age (although the author acknowledged that low recidivism in older offenders might actually reflect a lack of detection). However, as incest offenders tend to be older at conviction than other types of sex offenders, the assumption of risk reduction with age may be misleading-- at least when the criterion for increased risk is set below the age of 25 years. A risk assessment tool designed
for incest offenders may require the criterion of decreased risk with age to be set at a higher age, for example at 35 years.

Prior non-sexual violence (Static-99)

Prior non-sexual violence refers to prior convictions for violent offences. Although research suggests that sexual offenders with a history of convictions for violent offences are more likely to recidivate to any crime (Hanson & Bussiere, 1998), there is some uncertainty as to whether or not this item will be of significant reliability in predicting recidivism in incest offenders, due to contention as to whether incest offenders are likely to have a history of violence. Some researchers observed incest offenders to be unlikely to have a history of criminal or violent convictions (Herman, 2000; Johnson, 2007), although Herman (2000) does acknowledge that incest offenders tend towards domestic physical assault which usually goes unreported. Other research found that 16.4% of incest offenders have prior convictions for a violent offence, compared to 18.6% for extra-familial and 27.6% for mixed-type offenders (Smallbone & Wortley, 2006).

A study addressing factors predictive of recidivism in incest offenders reported that violent recidivists had, on average, a significantly higher number of prior violent and criminal charges or convictions, although there was no significant relationship with sexual or general recidivism (Firestone et al. 1999). The prior non-sexual violence item of the Static-99 is operationalised so that prior convictions, but not charges, are counted, warranting concern as to whether it will be sensitive as a risk assessment item in a sample of incest offenders who may be unlikely to have an extensive criminal history. Prior non-sexual violence may act as a significant predictor of violent recidivism, although is unlikely to bear a significant relationship to sexual or non-sexual non-violent recidivism.
Prior sex offences (Static-99)

Small but significant correlations exist between a history of sexual offence convictions and sexual recidivism in sex offenders, as found by a meta-analysis of sex-offender recidivism studies \( (r=0.19; \text{Hanson & Bussiere, 1998}) \). However, there remains contention as to whether this item will be useful as a predictor of sexual recidivism in incest offenders. Indeed, some researchers reported that incest offenders are unlikely to have been convicted of previous criminal offences- and therefore of previous sexual offences (Johnson, 2007; Herman, 2000). Smallbone and Wortley (2000) to some extent supported this contention when they reported that, although 61.6% of their sample of incest offenders had a prior criminal conviction, these convictions were significantly less likely to be for a sexual crime (10.8%) than are the convictions of extra-familial (30.5%) or mixed-type sex offenders (41.1%; Smallbone & Wortley, 2000).

Prior sexual offences may, however, still be useful as predictors of recidivism in incest offenders, as the scoring of the Static-99 permits prior sexual charges to be counted as well as prior convictions, due to high levels of observed attrition between charges and convictions for sexual offences. This renders the item more sensitive and thus potentially more useful, if incest offenders have any significant tendency towards having faced previous charges for sexual offences. A study of incest offenders in the USA, (Firestone et al. 1999) reported that a higher number of prior sexual charges or convictions was a significant predictor of sexual, although not violent or non-sexual non-violent recidivism. This result warrants further investigation of whether prior sexual offences may be of sufficient predictive validity for use in recidivism risk assessment for incest offenders.
Prior sentencing dates (Static-99)

For an offender to receive a score of 1 for this item, indicating increased risk, he must have at least four prior sentencing dates, not including dates in which the only sentence received was a fine. Previous research has found small but significant correlations exist between a history of criminal convictions and sexual ($r=.13$), as well as violent ($r=.11$) and general ($r=.23$) recidivism (Hanson & Bussiere, 1998).

However, there is some doubt as to whether this item may be of sufficient sensitivity to act as a significant predictor of recidivism in a sample of incest offenders, due to the contention of some researchers that incest offenders are unlikely to have any prior criminal convictions, let alone more than four (Johnson, 2007; Herman, 2000). By contrast, other available evidence does not support these observations: for example, Smallbone and Wortley (2000) reported that 61.6% of their sample of incest offenders had a prior criminal conviction, compared to 61.0% for extra-familial and 69.0% for mixed-type offenders.

In a sample of incest offenders in the USA, both sexual and general recidivists on average had a significantly higher number of criminal convictions prior to the index offence than did non-recidivists (5 vs. 1; Firestone et al. 1999), however there was no segregation of prior sexual from prior criminal convictions. Violent recidivists were also found to be more likely to have a higher number of prior violent and criminal convictions than were non-recidivists (Firestone et al. 1999).

Further research is necessary to investigate the likelihood of incest offenders to have prior criminal, non-sexual convictions, and whether these may act as sufficiently predictive variables in assessing sexual, violent or non-sexual non-violent recidivism risk.
Prior non-contact sexual offences (Static-99)

Little research is available examining the propensity for sexual offenders in general or incest offenders in particular to have prior convictions for non-contact sexual offences. Amongst the available evidence is a reported correlation of $r=.09$ between prior convictions for non-contact sexual offences and sexual recidivism, a result approaching although not attaining statistical significance (Hanson & Bussiere, 1998). No significant link has been reported between prior non-contact sexual offences and violent or non-sexual non-violent recidivism.

If incest offenders are, as reported by Smallbone and Wortley (2000), less likely than other sexual offender types to have a history of sexual offence convictions, it follows that they would also be unlikely to have prior convictions for non-contact sexual offences, even had these occurred. There are little or no available data that address the tendency of incest offenders towards engaging in (or being convicted of) non-contact sexual offences, although Johnson (2007) noted from clinical observation that incest offenders are likely to engage in paraphilias, including non-contact sexual offences such as peeping, exhibitionism, or stealing underwear. Further research is required to assess the usefulness of this item as a risk factor for sexual recidivism in incest offenders.

Unrelated victims (Static-99)

Research indicates that sexual offenders who have only offended against family members are less likely to recidivate to any crime than those who have offended against extra-familial victims (Hanson et al. 1993; Gelb, 2007). Although this item may be effective in comparing incest versus other types of sexual offenders, or in risk assessment in mixed-type offenders who have abused both within and outside of their families, it would appear to
be insensitive in distinguishing between high and low risk incest offenders who have no other sexual convictions as, by definition, they are related to their victims.

However, the coding rules of the Static-99 may render unrelated victims both sensitive and useful as predictors of recidivism, due to the difference between the Static-99 and legal definitions of “unrelated”. For Static-99 to consider a victim to be “related” to the offender, the offender must be a biological relative, or have been living with the victim for at least two years. By contrast, an offender is legally considered to be an incest offender if he is the legal guardian of the child, or is in an intimate relationship with the legal guardian of the child. An incest offender who is, for example, the child’s stepfather, but has resided with them for less than two years would be given a score of one, indicating increased risk. Therefore there is a potential basis for the use of unrelated victims as a risk factor for sexual, violent and general recidivism.

Intimacy deficits (SONAR)

Frisbie, 1969 (in Hanson & Harris, 2003) reported that “grave difficulties in establishing meaningful relationships with adult females” is one of the best predictors of sexual recidivism. As previously noted, Hanson and Bussiere (1998), found that offenders who have never been married are at significantly higher risk of sexual re-offending than those who have. One study reported a correlation of $r=.10$ was found between current intimacy deficits and sexual recidivism (Hanson & Harris, 2003), whilst a meta-analysis of sex-offender recidivism studies reported current intimacy deficits to have small but significant correlations with all types of recidivism (Hanson & Morton-Bourgon, 2005). However, some of these correlations were reduced to insignificance when subjected to 95% confidence intervals, bringing these results into question.
The existing data do not reliably demonstrate the usefulness of current intimacy deficits in sexual offender populations, and did not examine incest offenders. Therefore this item is a questionable predictor of any type of recidivism in incest offenders.

Attitudes tolerant of sexual assault (SONAR)

Deviant sexual attitudes are operationalised in the SONAR by degree of agreement with statements condoning or minimizing rape or child sexual assault (e.g., “some children are mature enough to enjoy sex with adults” or “some rape victims deserve what they get”). Researchers acknowledge deviant sexual attitudes to be common in rapists and child sexual offenders (Hanson & Harris, 2003; Johnson, 2007), and some studies have shown these attitudes to be significantly correlated with sexual, but not violent or general recidivism in child sexual offenders (Hanson & Bussiere, 1998; Hanson & Harris, 2003). The latter study reported a correlation of $r=.31$ between these attitudes and all recidivism. However, a meta-analysis of sex-offender recidivism studies failed to significantly correlate deviant sexual attitudes with any type of recidivism (Hanson & Morton-Bourgon, 2005). Further research is required to clarify these conflicting results.

There is little available research examining the relative propensity of incest offenders, as opposed to other sexual offender-types, to hold attitudes tolerant of sexual assault, however, there seems little evidence to indicate that these groups would differ significantly. Thus, attitudes tolerant of sexual assault are potentially of value for risk assessment for sexual recidivism in incest offenders.

Increased anger/hostility (SONAR)

The inclusion of increased anger/hostility as a risk factor of the SONAR is based upon a correlation of $r=.10$ between increased anger/hostility and sexual recidivism in a sample of
non-incestuous sex offenders (Hanson & Harris, 2003). By contrast, Firestone et al. (1999) found no significant link between high levels of hostility and any type of recidivism in incest offenders. Further investigation is required to clarify these inconsistent results, and to extend previous research to an Australian sample.

The finding of Proulx et al. (1996) that increased negative mood states can induce or heighten deviant sexual fantasizing in sex offenders, could theoretically extend to increased anger and hostility, however, this relationship was not addressed by that study. Therefore, increased anger/hostility is a questionable predictor of any type of recidivism in incest offenders.

Victim access/grooming (SONAR)

Item 9 of the SONAR, victim access/grooming, may be of particular concern for recidivism risk assessment in incest offenders, despite the findings of Hanson and Harris (2003), that increased victim access is significantly correlated with sexual recidivism in other sexual offender-types ($r=.23$). An offender is given a score of 1 for this item if they have increased access to prior or potential victims, or are engaging in grooming behaviours such as sexualized talk, “special” activities alone, or provision of treats/bribes. There are potential problems for the use of this item with incest offenders, due to cases in which offenders undergo family reunification.

An offender who is reunified with his family would receive a score of 1 for victim access on the SONAR, indicating more access to children and higher risk. Whilst there is no doubt that access to children is a risk factor for these offenders, and that some reunified offenders do recidivate against prior victims, use of this factor may be misleading as reunified offenders are grouped with offenders who seek unapproved, sexually-motivated contact with children. Furthermore, the presence of grooming behaviours is not necessary for
an offender to receive a score of 1 for victim access. An offender who is approved for family reunification by a treatment program would receive the same score on this item as an offender who sought access to children without approval. Some measures to avoid confounding these groups may be needed in order for this item to be useful as a predictor of sexual, violent or non-sexual non-violent recidivism in incest offenders.

Items with low validity for assessing recidivism in incest offenders

History of living with an intimate partner (Static-99)

Typically, a history of living with an intimate partner is a protective factor against recidivism in sexual offenders, as “the form of sexuality that develops in the context of pervasive intimacy deficits is likely to be impersonal and selfish and may even be adversarial” (Hanson & Morton-Bourgon, 2005, p.1154). Sexual offenders who have been married are at significantly lower risk of recidivism than are those who have not (Hanson & Bussiere, 1998). However, a history of intimate relationships is unlikely to be a useful predictive factor for any type of recidivism in incest offenders, as the majority of incest offenders are or have been married or lived in de-facto relationships (Herman, 2000). By the very nature of their crimes, incest offenders are rendered more likely than extra-familial sex offenders to have lived in an intimate relationship. As such, this item may lack statistical sensitivity in a sample of incest offenders.

Index non-sexual violence (Static-99)

Index non-sexual violence refers to violence which accompanied the index offence, including such acts as assault, breach of an AVO, or threat of assault with a weapon. The index offence is generally defined in the Static-99 as the most recent sexual offence for which the offender has been charged. In this study, the index offence is the incest offence or
offences which brought the offender to be assessed for treatment at the Cedar Cottage Pre-Trial Diversion Program (detailed in later sections).

Existing data indicate that a history of violence is predictive of future violence in a variety of offender types, including incest offenders (Firestone et al. 1999). Hanson and Bussiere (1998) reported significant correlations of prior non-sexual, violent convictions with violent ($r=.21$) and general ($r=.20$), although not sexual ($r=.05$) recidivism in sex offenders.

Whether or not this item is a reliable predictor of any type of recidivism in incest offenders is a matter of some concern, due to the observations of Johnson (2007) and Herman (2000) that incest offenders are less likely to use violence in the commission of their crimes than are other types of sexual offenders. Even if they do tend to be violent, Hanson and Morton-Bourgon (2005) reported in a meta-analysis of sex-offender recidivism studies that use of violence or force in sexual offending was a potentially misleading risk factor, not significantly related to any type of recidivism. Further research is necessary to clarify these inconsistent results, and to ascertain whether index non-sexual violence is useful as a risk factor for any type of recidivism in incest offenders.

Stranger victims (Static-99)

Victimization of strangers is significantly correlated with sexual recidivism in sexual offenders ($r=.15$; Hanson and Bussiere. 1998). However, this item by definition would seem to be an inappropriate predictor for offenders who have been convicted of sexual abuse within their families. Although this item is of demonstrated use with extra-familial or mixed-types offenders, this item is totally redundant in any study which exclusively investigates incest offenders who have not been convicted of other sexual offences.
Use of the Static-99 and SONAR in this study

The Static-99 and the SONAR are both largely untested in primary samples of incest offenders, warranting extensive research as to their suitability as risk assessment tools for such a sample. Whilst the Static-99 contains several items which appear to have low validity for risk assessment in incest offenders (such as stranger victims), it is hypothesised to be a moderate predictor of all types of recidivism in this study, based on the findings of Bartosh et al. (2003) that it was a significant predictor of sexual, violent and general recidivism in their small sample of incest offenders.

There are no prior data on which to base assumptions concerning the predictive validity of the SONAR in a sample of incest offenders, due to the relative lack of research investigating its predictive validity for recidivism in any type of sexual offenders. Although many of the SONAR items have high face validity for assessing recidivism risk in sex offenders, including incest offenders, many of these have not been adequately evaluated as predictors of recidivism (e.g., attitudes tolerant of sexual assault). Overall, the Static-99 is therefore expected to be a better predictor of any type of recidivism than is the SONAR for this sample.

The Cedar Cottage Pre-Trial Diversion Program

The Cedar Cottage Pre-Trial Diversion Program, situated in Westmead, NSW, is a community based, mandated treatment program for incest offenders. The program is pursuant to the Pre-Trial Diversion of Offenders Act 1985, which concerns offenders who are the guardian or parent of the victim. Offenders who intend to undertake the program are diverted from the judicial system and assessed for suitability for treatment at Cedar Cottage by the director of the program.
To be eligible to attend the Cedar Cottage program, an offender must plead guilty to all incest offences with which he has been charged. The incest charges should not have involved overt use of force or violence, and the offender must not have been previously convicted of any contact, sexual offence, although he may have been previously charged with a contact offence, or convicted of a non-contact offence. To avoid incarceration, the offender must comply with the program; attend all designated treatment sessions, live in a residence approved by the program director, and have no contact of any kind with any child under 16 years of age, including his own children, except as required by treatment. Treatment duration is a minimum two years, although a third year may be authorised by the program director, pending court approval, if an offender requires additional time to complete the program. Breach of these conditions, or failure to complete the program within a satisfactory time frame, may result in removal from the program, at which time the offender would return to court and face prescribed punishment such as incarceration.

Since the program’s inception in 1989, over 250 offenders have been referred to Cedar Cottage, of whom fewer than half were accepted. The efficacy of the treatment program in reducing recidivism has never to date been formally or empirically assessed.

Method

Participants

Participants were 214 males referred by NSW courts for treatment at Cedar Cottage between 1989 and 2002. Of these, 123 were deemed unsuitable to attend during the preliminary eight-week screening stage and were returned to court, 46 satisfactorily completed the program; and 39 either withdrew from the program before completion, or breached their treatment agreements and were returned to court.
Design

This was a quasi-experimental, retrospective study, examining differences between subjects (treated vs. non-treated, and recidivists vs. non-recidivists) in terms of scores on the Static-99 and the SONAR.

Materials

Data for the Static-99 and SONAR were coded from participants’ case files, which are securely stored at Cedar Cottage and maintained by on-site personnel. All case files contained: a) police reports and interview transcripts from the victim and offender as well as other parties such as witnesses, family members, or teachers, b) records of assessment interviews by Cedar Cottage staff, including summaries of issues discussed, and c) records of interviews with the offenders’ families/friends/employers/victims during assessment. The files of offenders who were accepted into treatment also contained records of individual and group treatment sessions for the offenders, tri-monthly progress reports, and compulsory journals and assignments by offenders, which detail current and previous life events. Some case files also contained reports from solicitors or psychological/psychiatric practitioners, and court transcripts. The majority of information required by the Static-99 and SONAR was obtained from the assessment and treatment records.

There was no need to obtain consent from participants, as no personal details are being published, and they had already signed agreements at Cedar Cottage, allowing their case files to be stored and used for approved purposes by the program.

Procedure

Recidivism was operationalised at the lowest possible threshold of detection; which were reports (rather than re-arrest, charge or conviction) of sexual, violent and non-sexual
non-violent offences. This was done in an attempt to minimize the effects of attrition between reporting and conviction, and to compensate for known under-reporting of sexual offences (Herman, 2000). Nevertheless, recidivism reports may still comprise conservative measures of the actual rate of re-offending.

Sexual recidivism was operationalised to both contact and non-contact offences (including rape, sexual assault, indecent assault, acts of indecency, indecent exposure, peep and pry, and possession of child pornography). Violent recidivism included any non-sexual violent crime (such as attempted or actual assault, assault with a weapon, wounding, armed robbery, intimidation, stalking and kidnapping). Non-sexual non-violent offences included all non-sexual, non-violent criminal offences (including stealing, break-and-enter, supply or possession of controlled substances, possession of stolen goods, exceeding prescribed concentration of alcohol whilst driving, and fraud offences such as obtaining benefit by deception). Breach of an Apprehended Violence Order (AVO) was coded as a non-sexual non-violent offence unless the COPS database specified that the breach had involved a physical or sexual assault, in which cases it was also coded as a violent or sexual offence.

Data on recidivism and prior criminal history were provided to Cedar Cottage by the NSW Police. These data were compiled from the Computerised Operational Policing System (COPS) database, created in 1994 to record information pertaining to incidents of crime. Information from before 1994 was obtained by the NSW Police from microfiche records. Data provided included incident and charge dates for offences (including reports which did not lead to charges), victim information, offence descriptions, and court and sentencing outcomes. Additional data on recidivism and incarceration were provided by the Bureau of Crime Statistics and Research (BOCSAR) and the NSW Department of Correctional Services.
The Static-99 items pertaining to criminal history (index non-sexual violence, prior non-sexual violence, prior sex offences, sentencing dates, and non-contact sex offences) were coded by the author from the offender information contained in the COPS database. The items pertaining to stranger victims, unrelated victims and history of living with an intimate partner, were coded from the case files maintained at Cedar Cottage. The items offender age and male victims were coded from a database at Cedar Cottage, which recorded historical variables such as date of birth, number and gender of victims, and offender marital status at the time of offence.

Risk factors for the Static-99 (such as male victims) are scored 1 if present and 0 is absent, with the exception of prior sex offences, which is coded 0 if there are no prior charges or convictions, 1 if there are less than two charges or a single conviction, 2 if there are between three and five charges or between two and three convictions, and 3 if there are more than five prior charges or four or more convictions. For item 6, prior sentencing date, the offender is given a score of 1 if he has had more than four separate prior sentencing dates which resulted in a conviction. Protective factors (such as history of living with an intimate partner) are scored 0 if present and 1 if absent. Scores of 0 or 1 are “low risk”, 2-3 as “low-moderate risk”, 4-5 as “high-moderate risk”, and 6 or more as “high risk”. Full coding rules for the Static-99 are supplied in Appendix A.

Data collection for the SONAR took place at Cedar Cottage. Data were collected by the author, with the assistance of five intern forensic psychologists undertaking a research placement for their Masters of Psychology at the University of New South Wales. Of the 208 participants, 121 files were coded by the author, and the remainder by the students.

The stable risk factors of the SONAR (intimacy deficits, social balance, attitudes tolerant of sexual assault, and sexual and general self-regulation) are scored as follows; 0-
never a problem; 1- slight/possible problem, and 2- yes, a problem. Acute factors (substance abuse, negative mood, anger/hostility and victim access) are scored 1 if the offender has shown recent deterioration in handling the problem, 0 if there has been no change, and -1 if he has shown improvement. The total score for acute factors is added or subtracted from the stable factor score to gain the offender’s total score. Total scores of -4 to 3 are deemed “low risk”, 4-5 as “low-moderate”, 6-7 as “moderate”, 8-9 as “high-moderate” and 10-14 as “high”. The full coding rules for the SONAR are supplied in Appendix B.

Inter-rater reliability check for SONAR

A sample of 13 randomly selected files were inter-rated and subjected to the following indices of inter-rater agreement:

1. Correlation coefficients between total scores of the first and second ratings.

2. Kappa (Fleiss, 1971), where a result is obtained between 1, which would indicate perfect agreement between raters, and -1, which would indicate perfect disagreement. A kappa of 0 indicates a chance level of agreement between raters. A kappa value of less than .20 indicates poor strength of agreement, .21-.40 fair, .41-.60 moderate, .61-.80 good, and .81-1.0 very good strength of agreement (Altman, 1991).

The study was double-blind, in that coders were not aware which participants had recidivated until after data coding was complete, with the exception of two participants, known to have sexually reoffended. Data for these two participants were included in the analyses on the basis that their scores were checked by three raters, and found to be unbiased by this awareness.

Ethical approval for the study was obtained from the University of New South Wales School of Psychology Ethics Department.
Hypotheses

1. Offenders who completed the treatment program are significantly less likely to sexually recidivate than non-completers. There will be no significant differences between completers and non-completers in terms of tendency towards all, violent or non-sexual non-violent recidivism.

2. Combined Static-99 and SONAR scores will have greater predictive validity than either test alone, for all, sexual, violent, and non-sexual non-violent recidivism.

3. Both Static-99 and SONAR total scores will be significant predictors of all recidivism categories. The Static-99 total scores will be of greater predictive validity when the criterion age is set at 35 years than at 25 years of age.

4. Two static predictors, history of living with an intimate partner and stranger victims, will have little or no predictive validity for any type of recidivism in this sample, due to a lack of variation and associated problems with statistical sensitivity.

5. The static predictor; offender age, will have better predictive validity when the criterion age is set at 35 years than at 25 years, although both criteria will be significant predictors of all types of recidivism.

6. The three static predictors; index non-sexual violence, prior sex offences, and unrelated victims will not demonstrate predictive validity for any type of recidivism.

7. The static predictors; prior non-sexual violence, and prior sentencing dates, will be significant predictors of all, violent and non-sexual non-violent recidivism.

8. The static predictors; prior non-contact sex offences and male victims, will be significant predictors of sexual recidivism.
9. The stable-dynamic predictors; intimacy deficits, social influences, and general self-regulation will be significant predictors of all types of recidivism. Sexual self-regulation will be a significant predictor of sexual and violent recidivism, and attitudes tolerant of sexual assault will be significant predictors of sexual recidivism.

10. The acute-dynamic predictors; drug/alcohol abuse and negative emotional states will be modest predictors of all types of recidivism. No predictive validity is hypothesised for anger/hostility or victim access for any type of recidivism.

Analyses

Survival analysis using Cox proportional-hazards regression

Survival analysis originated in medical research, and allows estimation of the degree of predictive validity of particular risk factors against an outcome, which in this case is recidivism. Cox proportional-hazards (Cox ph) regression analyses were undertaken using SPSS v15.0, as they have been used extensively in similar studies (e.g., Hanson et al. 1993; Stoolmiller & Blechman, 2005), and because this analysis is tolerant of the different lengths of time between subjects over which recidivism may occur.

The dependent variable (DV) is time until recidivism, operationalised as the time in days between the date of each offender’s referral to the program, and an end-date. If the offender recidivated, the end-date was the incident date of the re-offence; if the offender died, the end-date was his date of death. If the offender is had not recidivated, the end-date was the end of the observation period, which was the 1st of October, 2007. In cases where an offender was incarcerated after referral to the Cedar Cottage program, the number of days of incarceration were subtracted from the survival time, in order to reflect the amount of time that the offender was able to recidivate in the community.
The Cox ph analysis allows estimation of the linear relationships between multiple independent variables and recidivism. The probability of the recidivism as predicted by the IV is referred to as the hazard ratio. A hazard ratio of 1 indicates that the IV has no effect upon the outcome. For dichotomous variables, a ratio of 2 means that each extra unit of the IV doubles the chance of the outcome, whilst a ratio of 0.5 lessens the chance of the outcome by one half for each extra unit of the IV. For continuous variables, a ratio of 2 doubles the risk of the outcome for each unit increase on the IV. The following analyses were conducted:

1. Combined Static-99 and SONAR scores (with age set at 25 and 35 years) against all types of recidivism.
2. Static-99 total scores (with age set at 25 and 35 years) against all types of recidivism.
3. SONAR total scores against sexual, violent and general recidivism.
4. All individual items of the Static-99 against sexual, violent and general recidivism, and an additional offender age item with age set at 35 rather than 25 years.
5. All individual items of the SONAR against sexual, violent and general recidivism.

Results

214 participants were included in the Static-99 analyses.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Range of scores</th>
<th>Median score</th>
<th>Mean score</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age under 25</td>
<td>0 to 1</td>
<td>0</td>
<td>.019</td>
<td>.138</td>
</tr>
<tr>
<td>Age under 35</td>
<td>0 to 1</td>
<td>0</td>
<td>.250</td>
<td>.434</td>
</tr>
<tr>
<td>History of living with an intimate partner</td>
<td>0 to 0</td>
<td>0</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Index non-sexual</td>
<td>0 to 1</td>
<td>0</td>
<td>.048</td>
<td>.214</td>
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<tr>
<td>Risk factor</td>
<td>Range of scores</td>
<td>Median score</td>
<td>Mean score</td>
<td>Standard deviation</td>
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<tr>
<td>---------------------------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Intimacy deficits</td>
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<td>1.368</td>
<td>.683</td>
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<td>Social balance</td>
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<td>.484</td>
</tr>
<tr>
<td>Attitudes</td>
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<td>1</td>
<td>.841</td>
<td>.752</td>
</tr>
<tr>
<td>Sexual self-esteem</td>
<td>0 to 2</td>
<td>1</td>
<td>1.181</td>
<td>.561</td>
</tr>
</tbody>
</table>

Table 2: Summary of participant scores on the Static-99.

Of the 214 participants included in the study, 181 were included in the SONAR analysis. The remaining 33 participants were excluded from the SONAR analyses due to a lack of information in their case files to allow a reliable SONAR assessment. These participants either did not attend assessment at Cedar Cottage, or attended their first assessment only to state that they were not interested in participating in the program.
<table>
<thead>
<tr>
<th>regulation</th>
<th>0 to 2</th>
<th>1</th>
<th>1.242</th>
<th>.679</th>
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<tr>
<td>General self-regulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td>-1 to 1</td>
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<td>-.022</td>
<td>.331</td>
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<tr>
<td>Negative mood</td>
<td>-1 to 1</td>
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<td>.187</td>
<td>.456</td>
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<td>Anger/hostility</td>
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<td>0</td>
<td>.110</td>
<td>.392</td>
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<td>Victim access</td>
<td>-1 to 1</td>
<td>0</td>
<td>.115</td>
<td>.462</td>
</tr>
<tr>
<td><strong>Total score:</strong></td>
<td>0 to 11</td>
<td>5</td>
<td>5.236</td>
<td>2.082</td>
</tr>
</tbody>
</table>

**Table 3:** Summary of participant scores on the SONAR.

**Inter-rater reliability check for SONAR:**

The correlation coefficient between original rating and inter-rating was $r=.83$ ($p<.01$, 95% CI .51 to .95), which can be interpreted as a strong correlation. Weighted Kappa was .535, which can be interpreted as moderate inter-rater reliability.

**Recidivism frequencies**

<table>
<thead>
<tr>
<th>Type of recidivism</th>
<th>Number of recidivists</th>
<th>Number of non-recidivists</th>
<th>Recidivism percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (any)</td>
<td>66</td>
<td>148</td>
<td>30.8</td>
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<tr>
<td>Sexual</td>
<td>23</td>
<td>191</td>
<td>10.7</td>
</tr>
<tr>
<td>Violent</td>
<td>19</td>
<td>195</td>
<td>8.9</td>
</tr>
<tr>
<td>Non-sexual non-violent</td>
<td>58</td>
<td>156</td>
<td>27.1</td>
</tr>
</tbody>
</table>

**Table 4:** Recidivism frequencies.
### Cox proportional-hazards regression analyses

<table>
<thead>
<tr>
<th>Recidivism risk factor</th>
<th>Recidivism type</th>
<th>Hazard ratio</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATIC-99</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score (age at 35)</td>
<td>Non-sexual non-violent</td>
<td>1.317</td>
<td>.024*</td>
</tr>
<tr>
<td>Total score (age at 35)</td>
<td>Violent</td>
<td>1.469</td>
<td>.058†</td>
</tr>
<tr>
<td>Age under 35</td>
<td>Non-sexual non-violent</td>
<td>1.753</td>
<td>.042*</td>
</tr>
<tr>
<td>Prior non-sexual violence</td>
<td>All</td>
<td>2.891</td>
<td>.000**</td>
</tr>
<tr>
<td>Prior non-sexual violence</td>
<td>Non-sexual non-violent</td>
<td>3.753</td>
<td>.000**</td>
</tr>
<tr>
<td>Prior non-sexual violence</td>
<td>Violent</td>
<td>4.225</td>
<td>.004**</td>
</tr>
<tr>
<td>Prior sentencing dates</td>
<td>All</td>
<td>2.176</td>
<td>.012*</td>
</tr>
<tr>
<td>Prior sentencing dates</td>
<td>Non-sexual non-violent</td>
<td>2.723</td>
<td>.001**</td>
</tr>
<tr>
<td>Prior non-contact sex offences</td>
<td>Sexual</td>
<td>8.870</td>
<td>.003**</td>
</tr>
<tr>
<td><strong>SONAR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>All</td>
<td>1.150</td>
<td>.032*</td>
</tr>
<tr>
<td>Total score</td>
<td>Non-sexual non-violent</td>
<td>1.173</td>
<td>.024*</td>
</tr>
<tr>
<td>Negative social balance</td>
<td>Non-sexual non-violent</td>
<td>1.634</td>
<td>.047*</td>
</tr>
<tr>
<td>Negative social balance</td>
<td>Violent</td>
<td>1.976</td>
<td>.058†</td>
</tr>
<tr>
<td>Sexual self-regulation problems</td>
<td>All</td>
<td>2.075</td>
<td>.003**</td>
</tr>
<tr>
<td>Sexual self-regulation problems</td>
<td>Non-sexual non-violent</td>
<td>2.162</td>
<td>.004**</td>
</tr>
<tr>
<td>General self-regulation problems</td>
<td>All</td>
<td>1.877</td>
<td>.003**</td>
</tr>
<tr>
<td>General self-regulation problems</td>
<td>Non-sexual non-violent</td>
<td>2.090</td>
<td>.002**</td>
</tr>
<tr>
<td>Increased victim access</td>
<td>Violent</td>
<td>.219</td>
<td>.008**</td>
</tr>
<tr>
<td><strong>COMBINED SCORES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined (age at 25)</td>
<td>All</td>
<td>1.149</td>
<td>.011*</td>
</tr>
<tr>
<td>Combined (age at 25)</td>
<td>Non-sexual non-violent</td>
<td>1.172</td>
<td>.007**</td>
</tr>
<tr>
<td>Combined (age at 35)</td>
<td>All</td>
<td>1.147</td>
<td>.010**</td>
</tr>
</tbody>
</table>
Non-completion of the Cedar Cottage program was not significantly associated with any type of recidivism.

Static-99 total scores were not significantly associated with any type of recidivism when the criterion age for increased risk was set at the original level of 25 years. When the criterion age was set at 35 years, Static-99 total scores were significantly associated with non-sexual non-violent recidivism and marginally associated with violent recidivism. For each point received on the Static-99 when age was set at 35, the hazard ratio increased by 1.317 ($p<.05$) for non-sexual non-violent and 1.469 ($p=.058$) for violent recidivism.

The individual risk factor; age under 35, was significantly associated with non-sexual non-violent recidivism. An offender aged under 35 years was at 1.753 ($p<.05$) times the risk of recidivism than was an offender over 35 years of age. The individual risk factor; prior non-sexual violence, was significantly associated with all, non-sexual non-violent and violent recidivism. An offender with prior non-sexual, violent conviction was at 2.891 ($p<.01$) times the risk of all, 3.753 ($p<.01$) times the risk of non-sexual sexual-non-violent, and 4.225 ($p<.01$) times the risk of violent recidivism than was an offender with no such history.

The individual risk factor; prior sentencing dates, was significantly associated with non-sexual non-violent and violent recidivism. For each point received on the prior sentencing dates item, the hazard ratio increased by 2.176 ($p<.05$) for non-sexual non-violent and 2.723 ($p<.01$) for violent recidivism.

Table 5: Significant results of Cox ph analyses. * denotes significant result at $p<.05$ level, ** denotes significant result at $p<.01$ level, † denotes marginal significance.

<table>
<thead>
<tr>
<th>Combined (age at 35)</th>
<th>Non-sexual non-violent</th>
<th>1.178</th>
<th>.004**</th>
</tr>
</thead>
</table>

* signifies significant result at $p<.05$ level, ** signifies significant result at $p<.01$ level, † signifies marginal significance.
The individual risk factor; prior non-contact sex offences, was significantly associated with sexual recidivism. An offender with prior non-contact sex offences was at 8.870 (p<.01) times the risk of sexual recidivism than was an offender with no such history.

Total scores of the SONAR were significantly associated with all and non-sexual non-violent recidivism. For each point received on the total score, the hazard ratio increased by 1.150 (p<.05) for all and 1.173 (p<.05) for non-sexual non-violent recidivism.

The individual risk factor; negative social balance, was significantly associated with non-sexual non-violent recidivism and marginally associated with violent recidivism. For each point received on the negative social balance item, the hazard ratio increased by 1.634 (p<.05) for non-sexual non-violent and 1.976 (p=.058) for violent recidivism.

The individual risk factor; sexual self-regulation, was significantly associated with all and non-sexual non-violent recidivism. For each point received on the sexual self-regulation item, the hazard ratio increased by 2.075 (p<.01) for all, and 2.162 (p<.05) for non-sexual non-violent recidivism. The individual risk factor; general self-regulation, was significantly associated with all and non-sexual non-violent recidivism. For each point received on the general self-regulation item, the hazard ratio increased by 1.877 (p<.01) for all and 2.090 (p<.01) for non-sexual non-violent recidivism. The individual risk factor; victim access, was significantly associated with violent recidivism. For each point received on the victim access item, the hazard ratio increased by .219 (p<.01). The individual risk factors; intimacy deficits, attitudes tolerant of sexual assault, increased substance use, increased negative mood and increased anger and hostility were not significantly associated with any type of recidivism.

Combined scores of the Static-99 and SONAR were significantly associated with all and non-sexual non-violent recidivism, both when the age was set at 25 and at 35 years of age. For each point received on the combined scores when age was set at 25, the hazard ratio
increased by 1.149 ($p<.05$) for all and 1.172 ($p<.01$) for non-sexual non-violent recidivism. For each point received on the combined scores when age was set at 35, the hazard ratio increased by 1.147 ($p<.01$) for all and 1.178 ($p<.0$) for non-sexual non-violent recidivism.

Discussion

Sexual and violent recidivism in the sample of this study were observed to occur at comparable rates to previous research with incest offenders, however non-sexual non-violent recidivism was observed at substantially lower rates than was found by previous research (Firestone et al., 1999; Gelb, 2007). This may reflect the fact that the current sample was comprised of offenders who were considered to be low-risk by the courts, as reflected by the fact that they were referred to a pre-trial diversion program.

Predictive validity of instruments

In contrast to hypotheses, and to the findings of Bartosh et al. (2003), the Static-99 did not demonstrate adequate predictive validity for all any type of recidivism in incest offenders. However, when the criterion age for increased risk was changed from 25 to 35 years, the Static-99 significantly predicted non-sexual non-violent recidivism, and predicted violent recidivism with marginal significance. This result confirms the hypothesis that altering the criterion age for increased risk would improve the predictive validity of the Static-99, although the manipulated Static-99 did not predict all or sexual recidivism as it had been hypothesised to do. The SONAR demonstrated predictive validity as hypothesised for all and non-sexual non-violent recidivism, although in contrast to hypothesis it did not predict sexual or violent recidivism.

As hypothesised, combined scores of the Static-99 and SONAR predicted all and non-sexual non-violent recidivism both when the criterion age of increased risk for the Static-99
was set at 25 and 35 years. In contrast to hypotheses, combined scores did not predict sexual or violent recidivism when Static-99 scores were calculated using either criterion age. Whilst there was little difference between the Combined scores using either criterion age in terms predictive validity for all and non-sexual non-violent recidivism, the Combined scores predicted all and non-sexual non-violent recidivism with greater statistical significance than the SONAR total scores, and non-sexual non-violent recidivism with greater statistical significance than Static-99 scores with age set at 35.

These findings imply that the neither the Static-99 nor the SONAR is, in its current format, a suitable tool for recidivism risk-assessment in incest offenders. Neither the Static-99 in its original format, the SONAR, nor the combined scores of these instruments was found to predict sexual or violent recidivism, which are arguably the most crucial recidivism categories to accurately assess for risk as they imply a greater degree of harm to victims than do non-sexual non-violent offences.

Predictive Validity of Individual Risk Factors:

Predictive Factors

Although numerous risk factors had been hypothesised to predict sexual recidivism, the only risk factor of either the Static-99 or the SONAR which significantly did so was prior non-contact sexual offences. This item was a highly sensitive predictor despite the relatively small number of offenders in the sample who had previous non-contact offences. This result demonstrates that this item may be just as useful in risk assessment for incest offenders as for other sexual-offender types. It is significant that the only predictor of sexual recidivism in incest offenders was an index of sexual deviance rather than an index of self-regulation or impulse control, as it rebuts the assumption of Wortley and Smallbone (2006), that incest
offenders are characterized primarily by low self-control rather than high levels of sexual deviance.

Age under 35 was a significant predictor only of non-sexual non-violent recidivism, whereas it had been hypothesised to predict all recidivism categories. The hypothesis that changing the criterion age from 25 to 35 years of age would increase statistical sensitivity was supported by this result. The finding implies that the assumption of decreased risk of non-sexual non-violent and violent recidivism beyond the age of 25 may be inaccurate for incest offenders, whose ages tend to be higher at first conviction than other sexual offender types. Further research is required to determine whether age under 35 is a reliable predictor of any recidivism type in incest offenders.

The Static-99 items; prior non-sexual, violent convictions and prior sentencing dates, were significant predictors of all and non-sexual non-violent recidivism. Prior non-sexual violence was also a significant predictor of violent recidivism – a result confirming the hypothesis that prior violence may predict future violence. Neither prior non-sexual violent or prior sentencing dates was a significant predictor of sexual recidivism, although both had been hypothesised to predict all recidivism categories.

The significant incidence of offenders with prior criminal convictions in this sample refutes the observations of Herman (2000) and Johnson (2007) that incest offenders are typically unlikely to have a criminal history, and demonstrates the usefulness of prior criminal convictions as predictors of future criminal convictions in incest offenders as well as other sex offender populations. Furthermore, these items produced large hazard ratios with high degrees of significance, indicating that they may be amongst the best predictors for future criminality.
The SONAR item; negative social balance, was found as hypothesised to be a significant predictor of violent and non-sexual non-violent recidivism, supporting the finding of Hanson and Harris (2003) that negative social influences are associated with greater criminal recidivism. However, in contrast to the hypothesis of the current study, a negative social balance did not predict all or sexual recidivism in incest offenders. As there has been so little research regarding the predictive validity of the SONAR or the individual items in contains, these findings urge further examination of the use of this item in recidivism risk assessment for both incest offenders and sexual offender populations in general.

The sexual self-regulation item of the SONAR was significant associated with all and non-sexual non-violent recidivism, although it had been hypothesised only to predict sexual and violent recidivism. The results of the current study are at odds with previous findings that sexual self-regulation is a significant predictor of sexual and violent recidivism (Hanson & Morton-Bourgon, 2005). One possible explanation for the findings that this item predicted all and non-sexual non-violent recidivism is that sexual self-regulation problems are highly correlated with general self-regulation problems, which also predict non-sexual non-violent recidivism. Further examination of this item is required to determine whether it may be reliably used to predict any type of recidivism across different samples of incest offenders.

The general self-regulation item of the SONAR was found to be a significant predictor of all and non-sexual non-violent recidivism, but not of sexual or violent recidivism, although it had been hypothesised to significantly predict all recidivism categories. The fact that it did not predict sexual recidivism further rebuts the hypothesis of Wortley and Smallbone (2006), indicating that sexual recidivism in incest offenders may not be an index of poor impulse-control. This finding also partially confirms the findings of Stinson, Becker and Sales (2008) that general self-regulation problems were predictive of antisocial behaviour, in that general self-regulation predicted general criminality but not overt
violence in this sample. The findings of the current study confirm the usefulness of general self-regulation problems as a predictor of general criminal recidivism.

Victim access was found to be significant predictor of violent recidivism, although it is difficult to explain this link. No known research has heretofore found victim access to predict violent recidivism. The small scale of the result urges further investigation of the usefulness of this item for recidivism risk assessment in incest offenders.

Non-predictive factors

Contrary to the hypotheses of this study, non-completion of the Cedar Cottage program was not associated with any type of recidivism. This finding implies the difficulties that clinicians face in assessing treatment applicants for recidivism risk, and would urge caution in the use of completion of a treatment program as a protective factor. Further examination of acceptance to or completion of sex-offender programs is required to determine whether it may reliably predict tendency to recidivate.

Contrary to the hypothesis that it would predict all types of recidivism, age under 25 years was not significantly associated with any type of recidivism. This may be due to the low number of offenders in this sample who were aged under 25 years, or may indicate that the assumption of decreased risk of recidivism beyond the age of 25 may be inaccurate for incest offenders. Further examination of this item is necessary to order to assess whether 25 years of age is a suitable criterion for decreased risk of recidivism in incest offenders, or to confirm the findings of this study, that it is not a suitable criterion age.

As hypothesised, there was insufficient variation in the data for either of the Static-99 risk factors; history of living with an intimate partner, or a history of stranger victims, to act as significant risk factors for any type of recidivism. In fact, there was no variation in the data
at all: none of the offenders in the sample had victimized strangers, and all had lived with an intimate partner. There is no indication that the sample of this group significantly differs from the overall population of incest offenders in terms of either risk factor. Intra-familial child sex offenders are highly likely to have lived with an intimate partner, in that they have fathered or acted as a guardian to children, and any offender who has victimized a stranger as well as children within his family is better classified as a mixed-type than an incest offender.

Also as hypothesised, the Static-99 item; index non-sexual violence, was not shown to be a significant risk factor for any type of recidivism. Due to a lack of other research in this area, it is impossible to ascertain whether this result indicates the unsuitability of index non-sexual violence as a risk factor for recidivism in incest offenders overall, or merely for the sample of incest offenders used in the current study.

As noted in previous sections, it is a stipulation of the Cedar Cottage program that applicants should not have engaged in violence during the commission of their sex offences. Whilst some of the offenders in this study had applied to Cedar Cottage despite violent convictions accompanying the index offence, the number may not reflect the actual propensity for incest offenders to apply violence or force whilst offending, or to be charged or convicted of doing so. If the propensity is actually low, the sample of this study may be comparable to the overall population. However, it seems likely that the Cedar Cottage stipulations against violent offenders did discourage or outright exclude a number of applicants, and therefore the propensity for incest offenders to use force or violence may be somewhat higher than is indicated by the sample used in this study.

As hypothesised, the Static-99 item; prior sexual offences, was also not predictive of any type of recidivism for incest offenders in this study. This result is possibly, if not probably, due to the Cedar Cottage requirement that applicants must not have prior
convictions for any other sexual offence. Most offenders with prior sexual convictions were therefore screened from the sample, although some juvenile convictions and prior charges were not screened and were counted on the Static-99. However, some doubt remains as to whether the number of offenders in this study who had prior charges for sexual offences was as high as in the overall sample of incest offenders. For example, Smallbone and Wortley (2000) found that 10.8% of their sample of incest offenders had a prior sexual conviction. Taking these results into consideration, prior sex offences may be a useful risk factor for recidivism in other samples of incest offenders who have not been subject to any screening criteria.

Also as hypothesised, The Static-99 item; unrelated victims, was not a significant predictor of any type of recidivism. A possible explanation for this lack of predictive validity was that there was no significant distinction between incest offenders with related or unrelated victims. Whether classified as “related” or not, all incest offenders in this sample, and presumably the vast majority of incest offenders in the overall population, shared a household with, and/or assumed guardianship of the victim, and therefore it may be misleading to classify any victims of incest offenders as unrelated. The unrelated victims item was designed to differentiate between intra and extra-familial sex offenders, and may not be sensitive enough to differentiate between high and low-risk incest offenders in the overall population.

Contrary to our hypothesis that it would predict sexual recidivism, the Static-99 item; male victims, was not significantly associated with any type of recidivism, despite the fact that around ten percent of offenders in this sample had victimized males. Further investigation of this item is necessary in order to determine whether it may be reliably used to predict any type of recidivism in incest offenders.
The SONAR items, intimacy deficits and attitudes tolerant of sexual assault, did not predict any type of recidivism, although intimacy deficits had been hypothesised to predict all recidivism categories, and attitudes tolerant of sexual assault were hypothesised to predict sexual recidivism. Neither of these items has been subject to extensive testing in the past beyond the initial experiments by Hanson and Harris (2003); therefore further research is necessary to determine their usefulness as risk factors for recidivism in incest offenders, and in sexual offender population in general.

The acute-dynamic items; increased negative mood and increased anger/hostility, were not significant predictors of any type of recidivism, although increased negative mood was hypothesised to be a modest predictor of all recidivism categories. Again, due to a lack of research with sexual offender populations in general, these results may indicate that these items are not suitable as a risk factor for recidivism with either incest offenders or other sexual-offender types. The results of the current study imply that the acute-dynamic risk factors are not suitable predictors of recidivism, as changes to an offender’s mood, substance use or victim access during the previous month (at the time of risk assessment) may not bear relevance to re-offences which occur after a period of months or years.

The finding that increased substance abuse was not a predictor of any type of recidivism is at odds with the hypothesis that it would modestly predict all types of recidivism, and the findings of Firestone et al. (1999), who reported that American incest offenders with higher scores on the M.A.S.T. were at increased risk of violent and general recidivism. These discrepant results may not actually be contradictory, due to methodological differences between these studies. Firstly, substance abuse was operationalised differently in the Firestone et al (1999) as in the current study. The M.A.S.T. is sensitive to high levels of alcohol abuse, whilst the substance abuse item of the SONAR is sensitive to recent variations in substance abusing behaviour, rather than high or low baseline levels. High baseline levels
of substance use should have better predictive validity for recidivism in incest offenders than do recent increases in substance use. Another explanation for these discrepant findings concerns the samples used by the two studies. The Firestone et al. (1999) sample was drawn from incarcerated offenders in the USA, whilst the sample of the current study was drawn from community-based offenders in Australia. Significant historical and psychosocial differences may also exist between these groups which could affect the predictive validity of substance abuse as a risk assessment item, however it is operationalised. The results of this study suggest flaws in the assumption that increased substance use may trigger recidivism in sexual offenders, including incest offenders.

Methodological limitations

One potential limitation to this study was the limited sources available through which to gather data concerning criminal history and recidivism. All criminal history and recidivism data was gathered from the NSW COPS and BOCSAR databases, which generally do not contain information regarding offences committed in other states of Australia, or in other countries. Some of the offenders in the sample may have had prior convictions from other jurisdictions which were not included in the study, and this could have resulted in their being given an over-conservative Static-99 score in this study, which did not accurately reflect degree of recidivism risk. As no data were available concerning recidivism outside of NSW, the observed rate of recidivism can be assumed to be conservative in relation to actual recidivism rates as some offenders may have re-offended in other jurisdictions. Although the database did, in some cases, record reports of offenders moving interstate (and the reported date of the offender’s move was coded as the recidivism end-date in these cases), it is probable that some offenders did recidivate in other jurisdictions and were not recorded.
There are some potential problems for the external validity of this study, due to possible differences between the sample used and the overall population of incest offenders. Firstly, the screening criteria of Cedar Cottage may have excluded a significant number of offenders who had used violence or force during offending, or who had prior sexual offence convictions. Secondly, the sample used in this study was comprised almost entirely of offenders who were fathers or stepfathers to the victim, to the relative exclusion of other relatives such as grandparents, uncles and adult brothers or cousins.

Implications for research

Total scores and individual risk factors of the Static-99 and the SONAR must be subject to extensive further testing to determine whether they can be reliably used to predict any type of recidivism in incest offenders. In particular, it is necessary to examined whether they have any predictive validity for sexual recidivism in different samples of incest offenders. It may be profitable for future research to focus on the manipulation of existing risk factors within the Static-99 and SONAR (e.g., heightening criterion ages, manipulating the criterion number of sentencing dates, or altering the time-frame for acute-dynamic risk factors) to determine whether these items may be useful when operationalised differently.

The finding that index non-sexual violence was not a predictor of any type of recidivism in incest offenders in this study strongly urges investigation into the relative proclivity of incest offenders, as opposed to other sex-offender types, to use violence or force whilst offending, and to test this item as a predictor of recidivism in a sample of incest offenders who have not been subject to the screening processes in place at Cedar Cottage. Without these investigations, it is impossible to determine whether use of violence/force in the index offence is an appropriate risk factor for any type of recidivism in incest offenders.
The relative proclivity for incest offenders to have prior sexual offence convictions must be subject to further empirical investigation, and this item must be tested in a sample of incest offenders who have not been screened for prior sexual offences. Further research is necessary in order to determine whether the finding of this study that prior sex offences were not significantly associated with any type of recidivism in this sample can be generalized to the overall population of incest offenders.

The only items of the SONAR which attained significance as predictors of violent or non-sexual non-violent recidivism (negative social balance, sexual and general self-regulation problems, and victim access) must also be further examined to determine whether they may be predictive of any type of recidivism in other samples of incest offenders. In particular, the finding of this study that victim access increased risk for violent recidivism must be subject to further scrutiny. Further findings that general self-regulation problems are not associated with sexual recidivism would further refute impulse-control hypothesis developed by Wortley and Smallbone (2006).

The findings of this study urge the development of a new risk assessment tool developed specifically for use with incest offenders. This tool would employ both static and dynamic factors, as, whilst some static factors and some dynamic factors were shown to be non-predictive in this sample, some factors from each test were predictive, implying that risk assessment for incest offenders may usefully employ both static and dynamic factors. However, a tool designed for use with incest offenders would not include items which have been found to have low sensitivity and predictive validity, such as stranger victims, unrelated victims, history of living with an intimate partner, or any of the SONAR’s acute-dynamic risk factors. Items which may be suitable for inclusion in such a tool would be sexual and general self-regulation, prior violent offences, prior sentencing dates, and prior non-contact sexual offences.
Implications for practice

The conservative predictive validity of existing measures indicates that actuarial instruments are fallible and must not be the sole or prominent basis of risk assessment for incest offenders. In their current format, neither the Static-99 nor the SONAR should be considered as suitable instruments with which to assess recidivism risk in incest offenders, particularly those in a community-based sample.

The findings of this study imply that clinicians undertaking risk assessment for incest offenders should selectively employ both static and dynamic risk factors in doing so, and clinicians in sexual offender treatment should target these dynamic risk factors. Currently, it appears that static factors examining prior criminal and sexual convictions may be suitable indicators of increased risk, whilst dynamic high-risk indicators such as sexual and general self-regulation may be targets for intervention by treatment programs.
References


