ASSESSING THE DANGEROUSNESS AND TREATABILITY OF SEX OFFENDERS IN THE COMMUNITY

Dr William Glaser
Consultant Psychiatrist
Forensic Psychiatric Services
Health Department of Victoria

IF IT IS DIFFICULT TO GIVE A COHERENT MEANING TO 'DANGEROUSNESS', THE combination of this term and the term 'sexual offender' produces a semantic impossibility. Dangerousness in sex offenders is equated with incurable evil by the courts, unspeakable terror by the community and therapeutic nihilism by professionals. The silver gun rapist and Mr Baldy (the child molester) incite images of despair and fear which no amount of statistical analysis or criminological wisdom will overcome.

Yet the current community concern about sexual violence is itself a sign of hope for the future. There appears to have been a huge expansion in society's knowledge-base about sexual offending: hopefully folk-myths such as those of sick offenders and 'stranger danger' have now been replaced by the reality that normal males perpetrate most sexual violence and that most offenders are known to their victims. With increasing knowledge has also come a range of attempts to do something other than simply incapacitate the offender: they may be crudely positivist hybrids of treatment and punishment approaches and their efficacy may be doubtful but at least they seek to address the very real problem of recidivism in this group.

The attitudes of the law and the community to such interventions is ambivalent. The 'sickness' of sex offenders, particularly child molesters, has been used to justify both indeterminate detention and the development of non-custodial alternatives for them, often on dubious clinical or

criminological grounds (Glaser 1988). Yet, as two recent Victorian cases show, treatability remains an issue (Fox 1991a; 1991b).

In *R v. McCracken*, the appeal by the Crown against a non-custodial sentence for an obviously recidivist paedophile, inspired by outrage in the mass media about the decision, was dismissed because the Full Supreme Court did not believe that the treatment plan contained in the original community-based order had been properly implemented, despite the offender himself having helped to sabotage it by hiding his medication in a shoe-box. In *R v. Roadley*, an appeal against a prison sentence for an intellectually disabled paedophile was upheld, the court noting that the lack of community resources (and hence the possible danger to the community) for the offender did not justify imprisonment where this was disproportionate to the crime.

These developments reflect a belief that treatability and dangerousness are quite distinct concepts. Specifically, treatability is as much a function of the legal and community response to the offender as it is of the offender's own characteristics. There is a requirement that the courts, parole boards, correctional agencies and service providers go beyond the crude assessment of suitability for treatment of an offender and consider such factors as resource allocation, efficacy of individual treatments, community attitudes and society's moral responsibilities to the offender.

The distinction between dangerousness and treatability implies that a classification of offenders more sophisticated than the current 'dangerous/ non-dangerous' dichotomy needs to be developed. At the very least, a scheme such as the following needs to be considered:

(a) treatable and not dangerous;

(b) not treatable and not dangerous;

(c) treatable and dangerous; or

(d) not treatable and dangerous.

In (a) and (b) treatment may not be necessary from the point of view of society and may well impose an added (if unintended) punitive component to the offender's sentence. In (c) both ethical and practical considerations would dictate that society make treatment facilities available to the offender. And in (d) society has an obligation to make sure that 'non-treatability' is not due to a lack of resources (as in *R v. Roadley*) or community prejudices.

Clearly, the knowledge-base to enable us to assign an offender to any one of these four categories is still rather slender. Nevertheless, an attempt is made in the rest of this paper to outline the factors which need to be considered when making such judgments. It is important to emphasise that such factors include social and political responses to the problem as well as the 'scientific' characterisation of the offender himself.

The Offences

There is no way of predicting the risk of future re-offending on the basis of the type and circumstances of the index offence, no matter how heinous the crime.

The problems of calculating recidivism rates in offenders, and sex offenders in particular, are well known: they include the low rate of reporting, laying of charges inappropriate to the circumstances of the offence, changes in legislative definition of the offence, and the 'attrition' between charging and sentencing (Cashmore & Horsky 1988; Furby et al. 1989; National Committee on Violence 1990, p. 29; Broadhurst & Maller 1991). Despite a clinical impression that many offenders (for example, homosexual paedophiles, exhibitionists) tend to 'specialise' in their offending preference, this is not borne out by sophisticated offender self-report studies (Abel et al. 1988) nor by recent Australian research on imprisoned offenders (Broadhurst & Maller 1991). It is possible that exhibitionists tend to sexually re-offend more than assaulters or paedophiles (Romero & Williams 1985) and incest offenders less than other sub-groups of sex offenders (but only after they are discovered) (Gibbens et al. 1978).

The extent of the harm done by sex offenders to their victims is only now being recognised. Admittedly, at one extreme, one-third of all sex offences (including rapes) reported to the police in Victoria in 1989–90 involved indecent exposure (Victoria Police 1990), a crime which, arguably, is more of a social nuisance than anything else. At the other end of the spectrum, although most rapists and child molesters inflict little physical damage on their victims, the psychological suffering caused can be immense. (National Committee on Violence 1990; a review of effects on child victims is contained in Finkelhor 1986).

Indeed, where child victims are involved, an ideology of minimal intervention in adult-child sexual contacts based on a 'children's rights' approach (*see* the readings edited by Constantine & Martinson 1981) or on the outrage of one populist criminologist at society's hypocrisy (Wilson 1981) no longer appears to be tenable.

The Offenders

There is broad agreement that the recidivist sex offender, whether serious or not, tends to be young and have an extensive prior criminal record (Furby et al. 1989). In Australia, Aboriginality is a risk factor for re-imprisonment of serious sex offenders (Broadhurst & Maller 1991) although clearly social and cultural factors result in a higher imprisonment rate generally for this group.

Other predictive factors for serious recidivism, although less well validated statistically, are based on clinical experience. These include the presence of antisocial personality features and substance abuse (Walker et al. 1984) and of aggressive or sadistic fantasies (Bluglass 1982).

There have been repeated attempts to elucidate predictors for response to treatment. A recent careful study of child molesters confirmed long-standing clinical hunches that heterosexual 'stranger' molesters benefit most, while those engaging in genital-genital contact with their victims do poorly.

Interestingly enough, penile strain gauge measurement of deviant sexual preference did not predict outcome (Marshall & Barbaree 1988). This last observation may arise from the unreliability of penile circumference measurement as compared to the measurement of penile volume (McConaghy et al. 1989).

Adolescents often are 'resistant' to treatment although, because patterns of serious later re-offending are often first noticed in this age-group, they deserve a trial of intensive interventions (McConaghy 1989). Other groups such as the intellectually disabled which have traditionally been thought to be unsuitable for the usual therapeutic techniques can now be helped with interventions especially tailored for them (Griffiths et al. 1989; Clarke 1989).

The Response by Professionals

Current facilities in Australia can offer treatment to only a small proportion of sex offenders: less than fifty offenders have passed through the Victorian Health Department's pilot treatment program in the last two years and only a handful of private practitioners have any interest in the area. Hopefully, however, even this tiny effort could have an appreciable impact on victimisation rates if the 'patients' are carefully selected: it is known that a small proportion of offenders may account for a disproportionate number of victims (Abel et al. 1987).

Treatment regimes used in Australia have slavishly followed North American trends in that they consist mainly of behaviour modification techniques and/or the use of libido-reducing medication, particularly anti-androgens. As well, incest offenders often undergo family therapy or counselling. The rationale for using such treatments is that they have been more extensively evaluated than others (*see* Berlin & Meinecke 1981). But there is also a realistic need to use these more intrusive and mechanistic treatments in offenders who are usually in treatment under compulsion (for example, court orders) and who usually attempt to deny or minimise their offences (Salter 1988).

Unfortunately this has meant that the mainstream literature has ignored techniques which possibly are more cognisant of the meaning of the offender's behaviour and the preservation of his dignity, such as group analytic therapy (Weldon 1991, pers. comm.). Since all treatment regimes have high drop-out rates (Furby at al. 1989) there needs to be a continuing awareness of alternatives which are more palatable to offenders.

Whether treatment, of whatever variety, works at all is still an open question. Caution needs to be exercised when reading the gloomy conclusions of the comprehensive review by Furby et al., cited above. Their study might have found no evidence for treatment efficacy but this opinion was based on a group of studies selected according to methodological criteria which could be considered as overly strict. For example, many valuable studies based on self-report or physiological outcomes were excluded because these measures have not been shown to correlate with recidivism rates; clearly, however, there may be good clinical reasons to believe such a correlation exists (and this is in fact the basis for many measures of treatment progress). Reasonably

well-designed studies showing decreased recidivism in a treated group compared with comparable non-treated controls have been published since this review (for example, Marshall & Barbaree 1988) and one recent Australian study has produced surprisingly good results using only modest interventions (McConaghy 1990).

One problem is that sex offenders are notorious long-term recidivists and any benefit from treatment may only be apparent after a lengthy period. Conversely, a really effective treatment program will have to emphasise long-term follow-up: the clinical impression is that it is this, rather than any specific treatment technique, which keeps offenders out of trouble (Bluglass 1982).

Finally, what must be stressed is that any treatment program is only as good as its staff and facilities will allow it to be. The response to the problem by Australian governments can be described as half-hearted at best. In Victoria, the pilot sex offenders treatment program is run by a community forensic psychiatric service which has an enormous range of other responsibilities including the provision of psychiatric and psychological reports to the courts, clinical support for community corrections staff, direct treatment responsibilities for a range of difficult and demanding clients (not just sex offenders), teaching in professional courses and consultation and liaison with other clinics, hospitals and service providers. The service is located in a dirty run-down building surrounded by scaffolding to make sure that its rotting concrete cladding does not fall onto passers-by; the antique lifts have minds of their own; the toilet facilities are inadequate and medical treatments (including injections) are administered in unsafe and unhygienic conditions.

Despite the chronic shortage of staff, there is not enough office-space and the security and privacy of both staff and clients suffer as a result. A lot of professional staff time is spent operating the switchboard, doing receptionist duties and filling out incomprehensible forms for the Health Department because of the paucity of secretarial assistance. It is indeed a tribute to the dedication of the staff that, while they are enduring these conditions, they do not think too often of their colleagues in private practice, only a couple of city blocks away, who earn large fees for compiling court reports which enthusiastically recommend 'treatment' for which they do not have to take responsibility.

The point of this dreary description is not that the Victorian government has neglected public forensic psychiatry: millions of dollars have been spent on refurbishing and staffing Victoria's two in-patient security units and the prison psychiatric service. Rather, it is a demonstration of state, community and professional ambivalence towards the issue of treatment. We are prepared to spend millions on patients who are safely locked up but become miserly over services located in the community where most offenders (including many dangerous ones) live. This ambivalence must eventually reflect on the standards of care in the community facilities which are resourced so grudgingly.

The Response by the Law

As the other papers at this conference have demonstrated, there is a continuing tension between an offender's civil liberties and the need to protect the

community. It may be impossible to both preserve individual legal rights and prevent at least a few dangerous offenders from being at large in the community.

In the case of rapists and child molesters, however, doubts have been raised recently as to what respect for their 'rights' really means. The evidence of woman and child victims has always been restricted by special legal rules (for example, the requirement for corroboration, the admissibility of the victim's previous sexual history) which reflect a fundamental mistrust of the reliability of such evidence. Thus the right of an accused sex offender to discount the evidence of his accusers may be no more than an expression of legal misogyny and paedophobia, fostered by the prejudices of male judges and legal commentators and hallowed by centuries of precedent. Indeed this prejudice may extend to 'protective' jurisdictions such as the family court and the children's jurisdiction (Scutt 1990). The law has only recently started to recognise these problems (Law Reform Commission of Victoria 1987; Brereton & McKelvie 1991).

Even if a conviction or a plea of guilty is obtained, the court often has too little information to guide it. The adverse psychiatric report prepared for a defendant's legal advisers rarely is put in evidence and the process of plea-bargaining inevitably reduces the number and severity of the charges. The tariff imposed thus may not reflect the seriousness of the original offence or offences. Yet on the other hand, the law's potential harshness may well prevent offenders from seeking appropriate help (McNiff 1987; Scott 1989). This is particularly so for those whom the law punishes severely because of their position of trust with their victims—these offenders include teachers, health care providers and others in situations of high risk.

The Response by the Community

The 1980s have witnessed an era of moral panic focused on issues such as sexual violence and child sexual abuse. No fewer than four Australian states have issued comprehensive reports on the problems of child sexual abuse within the space of a couple of years (Hewett 1986). However, it is still too early for us to take our fingers off the panic-button. Community and professional myths about sex offenders die hard. Rape is still seen as what is said to occur if the girl's parents come home too early (Bluglass 1982) and only twenty-five years ago, a leading Australian psychiatrist felt quite comfortable about blaming the victim for many cases of child sexual abuse:

> Can a man be entirely blamed for his relationship with a powdered and painted thirteen-year-old who looked at least eighteen and haunted low-class hotels to pick up drunks and offer them her favours for a small reward; or the garageman who was visited by a ten-year old eleven times for sexual purposes before she decided the recompense was inadequate and informed the police? (McGeorge 1966, p. 113).

Nevertheless, there needs to be some recognition that many of today's offenders were also yesterday's victims: a recent paper has provided an elegant and sophisticated explanation for the observation that those experiencing sexual abuse as children become offenders in adulthood (Marshall 1989). As well, certain offender groups, such as the intellectually

disabled, are more likely to have experienced significant levels of abuse, particularly while in institutional care (Glaser 1991). Where the state has been responsible for institutions in which abuse is known to have occurred, as has recently been discovered in Victoria (Wallace 1991), then there appears to be a moral obligation on society to provide rehabilitative and treatment-oriented dispositions for offenders from such backgrounds rather than punishment.

One of the major obstacles to developing this sort of understanding is the attitude of the media to sex offences. A study of British newspapers, both respectable and otherwise, over the last forty years, found little serious reporting of the subject and a great deal of sensationalism and titillation (Soothill & Walby 1991). An analysis of the Australian media along the same lines would, it is suggested, produce the same findings.

Some Conclusions

Although the science of sex offenders is still very crude, there is an increasing body of knowledge available which will help us to predict dangerousness. Clearly a drug-abusing psychopathic young rapist with aggressive fantasies and multiple previous convictions for violent offences is dangerous; on the other hand a first-time middle-aged exposer is probably not. The real difficulty is to think beyond the issue of dangerousness itself. Even if indeterminate detention is being seriously considered as a disposition, the fact is that most, if not all, 'dangerous' sex offenders will be released on to the streets sooner or later. Thus, it is in the interests of both society and the offender to perform the most comprehensive assessment possible of his treatment prospects.

Unfortunately, this is still not yet feasible. The outcome of treatment, even for the minority of sex offenders who might benefit from it, depends on much more than the offender's personal and clinical characteristics. The most ideal candidate for treatment is largely untreatable if the resources are not available, the treating staff are unable to provide adequate care, there are no means of evaluating treatment programs, the law deters offenders from accessing the service, judges do not have enough information to decide on appropriate dispositions, community attitudes become indiscriminately punitive or if the media fail to provide balanced and informative reporting of the issues involved.

These factors, as much as anything else, place the community at risk of harm from a particular sex offender. The use of one-dimensional models of individual dangerousness to predict such harm is not sufficient. The problem needs to be addressed not only at this level but also at the level of the social and political forces at work within our society.

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