INDIGENOUS JUSTICE CLEARINGHOUSE

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Sex offender treatment programs: effectiveness of prison and community based programs in Australia and New Zealand

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Introduction

In recent years debate has emerged over whether or not programs designed to treat sex offenders are effective in reducing sexual recidivism (Marques 1999). Resolving this debate is a difficult task, as evaluations of programs are often hindered by small sample sizes of treated sex offenders. Furthermore, if follow up periods in which sexual recidivism is measured after offenders complete treatment are not adequate, evaluations are unreliable in determining program effectiveness.

To overcome such problems international studies have used meta-analyses that collate the results from multiple evaluations to determine program effectiveness. A well-cited Canadian study was able to examine a sample of over 9000 sex offenders in four different countries by using the meta-analytic approach. The study found that 9.9% of treated sex offenders reoffended sexually, compared with 17.3% of non-treated sex offenders (Hanson et al. 2002). Similarly another study analysed the results from 69 different studies (N=22,000), finding that treated sex offenders reoffended sexually 37% less than untreated offenders (Losel & Schmucker 2005).

Nevertheless the sample sizes, recidivism rates and follow up periods of individual studies included in meta-analyses sometimes vary immensely from one another. Therefore this approach may exclude important findings, which are only produced by examining the effects of various different types of treatment programs individually.

Researchers have also acknowledged that the general sizes of treatment effects on sexual recidivism are not necessarily large (Hanson et al. 2002; Lievore 2004). However Marshall & McGuire (2003) found that treatment effect sizes produced from sexual recidivism studies were comparable with effect sizes produced from other types of treatment. These included treatment for those with mental health problems, those with physical health problems and those convicted of non-sexual offences (Marshall & McGuire 2003).

New Zealand has a number of long-running prison and community based treatment programs for adults and adolescents who sexually offend, most of which have been evaluated. In Australia treatment programs are available for adult, adolescent and Indigenous sex offenders, however little information is available on the scope and efficacy of such programs. Previous research has examined evaluations of sex offender treatment programs in Australia (Lievore 2004; Chung et al. 2006; Gelb 2007), however new evaluations have since been conducted. This study reviewed the evaluation results from eight New Zealand and five Australian treatment programs for adults and adolescents who sexually offend. The study also provides an overview of current methods for

addressing the treatment needs of Indigenous sex offenders.

Adult offenders

Sexual recidivism is predominantly measured by examining the reconviction rates of sex offenders (Gelb 2007), although this method may significantly underestimate the extent to which sexual reoffending occurs (Marshall & Barbaree 1988). A Canadian study found that when 'unofficial' data relating to sexual reoffending such as re-arrests and probation/parole records were combined with reconvictions, the recidivism rate was increased by 170% (Barbaree & Marshall 1988). Self-report data such as surveys completed by sex offenders are also useful for measuring sexual offences undetected by the criminal justice system; Gelb (2007) notes that studies using these methods tend to produce higher rates of sexual recidivism than those based on arrest and reconviction data. Such methods are often not feasible however and most of the evaluations that were reviewed in this study relied on reconviction data to measure sexual recidivism.

A prison based program for adult sex offenders operates in every state and Territory of Australia. In regard to adult offenders, evaluations were available from three prison based programs in Australia, two prison based programs in New Zealand and three community based programs in New Zealand. Other evaluations were not included in this study due to the use of short follow up periods, and/or the availability of only preliminary findings. No Indigenous sex offender treatment programs have been sufficiently evaluated in Australia.

In a recent overview of treatment program effectiveness, Lievore (2004) described the ideal evaluation design as randomly selecting a group of sex offenders who are willing to undergo treatment, then separating the sample into a treatment and non-treatment control group to compare the recidivism rates. However it has been acknowledged that due to the ethical implications involved in denying offenders treatment, this method is fundamentally unattainable (Lievore 2004; Laing et al. 2006). Marshall & Marshall (2007) took this issue a step further by analysing the random controlled trial design, concluding that it is not an appropriate method for measuring the effectiveness of sex offender treatment.

It has been noted that methodological differences in program evaluations may influence the inconsistencies in sexual recidivism rates (Marques 1999; Lievore 2004; Chung et al. 2006). As study designs differed across the evaluations included in the present study, care was taken when reviewing the results in relation to one another.

In Australia most treatment programs for sex offenders are based on overseas models that use cognitive behavioural therapy (CBT)-based methods to target the criminogenic needs of offenders. For a list of adult programs currently operating in Australia see Appendix C. While some programs are long running, few are allocated the resources and funding to undergo evaluations.

No Indigenous sex offender treatment programs have been sufficiently evaluated in Australia

Adult programs predominantly cater for sex offenders who are at low-moderate and moderate-high risk of reoffending. For example participants in the CUBIT program are separated from other inmates, and high-risk violent sex offenders tend to bypass treatment. Such offenders may be subject to extended detention/supervision orders if they are assessed as being at high risk of reoffending upon the completion of their sentences. Similarly those who categorically deny responsibility of their offences are usually not accepted into treatment programs, and therefore may serve their prison sentences untreated.

Effectiveness of adult programs

In New South Wales the Custody Based Intensive Treatment (CUBIT) program operates for moderate-high risk sex offenders, and the CUBIT Outreach (CORE) program operates for low risk sex offenders. Both programs are prison based and target the known risk factors for sexual reoffending such as empathy deficits, cognitive distortions and general self-regulation (Hoy & Bright 2008).

An evaluation conducted on the CUBIT programs (Hoy & Bright 2008) compared recidivism rates of 117 treated offenders with those predicted by the STATIC 99 risk assessment measure, an internationally used tool that assesses the recidivism risk of sex offenders. STATIC 99 risk probabilities are based on a large sample of sex offenders in the United Kingdom and Canada (Hanson & Thornton 2000). The study found that 8.5% of sex offenders who were treated at the CUBIT programs committed a further sexual offence in the follow up period (3.75 years), compared with the predicted sexual recidivism rate of 26% (see Appendix A) (Hoy & Bright 2008).

While these results are encouraging, two factors should be acknowledged. Firstly offenders within the STATIC 99 sample had 1.25 years extra in which to reoffend compared with those in the CUBIT sample; this factor was not believed however to have a significant impact on the overall recidivism comparisons (Hoy & Bright 2008).

Secondly care needs to be taken when comparing NSW CUBIT attendees' reconviction rates with those from offenders in Canada and the UK. The ability of police and courts to investigate and prove sexual offences may differ across jurisdictions; therefore the comparison of such recidivism rates attracts complications. Such problems may be overcome by establishing a risk assessment tool that is based on a sample of sex offenders in Australia. Nevertheless past research has indicated that CUBIT significantly reduces the dynamic risk factors associated with sexual reoffending (Mamone et al. 2002), thus corroborating the Hoy & Bright (2008) evaluation findings.

The Sex Offender Programs (SOP) unit in Victoria offers similar treatment methods to those at CUBIT, and also includes a program for special needs sex offenders. A 2007 evaluation of SOP examined recidivism rates of 330 offenders who entered the program (follow up period: average 4.5 years). The authors (Owen et al. In press) also analysed the recidivism rates according to STATIC 99 risk assessment. They found that offenders categorised by STATIC 99 as high-risk were much more likely to reoffend sexually than those categorised as low, medium-low and medium-high risk (Owen et al. In press). This finding is favourable to the accuracy of STATIC 99 as a risk assessment tool.

The authors found that:

- 4% of SOP treatment completers reoffended sexually
- 20% of those who withdrew from SOP reoffended sexually
- 10% of those who were removed from SOP reoffended sexually.

One point to consider however is that offenders who withdraw from treatment programs are likely to have different levels of motivation to address their offending behaviour (Lievore 2004). There is the possibility that program 'drop-outs' are more likely to reoffend with or without treatment, therefore treatment effects produced from studies that compare treatment completers with treatment drop-outs may be inaccurately amplified. The authors acknowledged that the absence of a comparison group limited them from making strong inferences regarding the treatment effects of SOP. In consideration of this factor however, the rate of sexual recidivism (4%) for offenders who completed treatment at SOP was irrefutably low.

A 2002 evaluation of the Western Australian Sex Offender Treatment Unit (SOTU) produced less positive results. The Western Australia study measured the recidivism rates of 2165 sex offenders who were referred to the SOTU from 1987 to 1999. Among other analyses the study compared non-treated offenders with treated offenders, finding no significant effects of treatment on rates of sexual recidivism (Greenberg, Da Silva & Loh 2002).

However as Lievore (2004) noted, systematic differences between the treated and non-treated group in the Western Australian study, such as risk category, Indigenous status and sentence length may have impaired the comparability of these groups. The authors themselves also noted that methodological limitations may have prevented the study from identifying smaller treatment effects, and identified inconsistencies across the data sources (Greenberg et al. 2002).

A prison based program for adult sex offenders operates in every State and Territory of Australia, however few have been evaluated

Treatment programs in New Zealand are delivered in a slightly different context to those in Australia. New Zealand programs tend to:

- focus predominantly on child sex offenders
- include strong cultural components in the treatment that benefit Indigenous and non-Indigenous offenders
- not separate Indigenous offenders from non-Indigenous offenders
- include strong relapse and integration components in the treatment.

The Kia Marama Treatment Program in New Zealand is for adult sex offenders against children. It has been placed on a par with treatment programs available internationally that are most effective in reducing sexual recidivism (Hanson et al. 2002). Treatment at Kia Marama is delivered in a group-based setting, which is seen to be more effective and allows group members to be challenged by other members (Bakker, Hudson, Wales & Riley 1998).

The program incorporates CBT and social learning theory elements, which include:

- understanding offending behaviour
- arousal conditioning, which is designed to identify and

decrease deviant sexual arousal
- victim impact and empathy
- mood management
- relationship skills
- relapse prevention
- relapse planning and aftercare.

A 1998 evaluation by Bakker et al. compared the recidivism rates of 238 adult sex offenders who underwent treatment at Kia Marama with those of 283 non-treated adults who were convicted of sexual offences against children between 1983 and 1987. Results indicated that treatment at Kia Marama more than halved the rate of sexual recidivism. While 21% of offenders who did not receive treatment were convicted of a further sexual offence, 10% of Kia Marama graduates reoffended sexually in the four-year follow up period (see Appendix A) (Bakker et al. 1998).

A more recent evaluation was conducted on the Te Piriti Special Treatment Program for child sex offenders in New Zealand (Nathan, Wilson & Hillman 2003). Te Piriti incorporates the same CBT treatment methods employed by Kia Marama but combines them with tikanga Maori, a holistic set of practices based on a Maori world view and understanding of the universe. The evaluation compared recidivism rates of Te Piriti graduates with the same control group used in the Kia Marama evaluation. Compared with the non-treated group's sexual recidivism rate of 21%, only 5.47% of offenders who completed treatment at Te Piriti reoffended sexually.

Maori offenders were also found to respond favourably to this program. Only 4.41% of Maori offenders reoffended sexually after receiving treatment at Te Piriti (Nathan et al. 2003), compared with 13.58% of Maori Kia Marama graduates (New Zealand Corrections 2003). These results are supportive of the argument that programs are more effective in reducing sexual recidivism when the design and implementation are attuned to the cultural background of offenders.

Community based programs in New Zealand were also found to be effective in reducing sexual recidivism. Lambie & Stewart's (2003) study included a sample of 175 offenders who were treated at one of three community based programs (SAFE Network Inc, STOP Wellington Inc and STOP Trust Christchurch), and compared them with a comparison group of offenders who did not receive treatment, as well as an Assessment Only group. The authors found that 5.2% of those who successfully completed one of the programs recidivated sexually, compared with 16% in the non-treated comparison group and 21% in the Assessment only group (Lambie & Stewart 2003).

… programs are more effective in reducing sexual recidivism when the design and implementation are attuned to the cultural background of offenders

More research needs to be conducted into community based programs for adult sex offenders in Australia. Aside from the Northern Territory and Tasmania there is at least one community based treatment program for adult sex offenders operating in each jurisdiction, however most have not been evaluated.

Evaluations of prison based adult treatment programs in Queensland and Western Australia, as well as a study on the NSW program at Cedar Cottage are currently being conducted, which when completed, will hopefully assist with drawing further conclusions on overall treatment efficacy.

Adolescents who sexually offend

International research suggests that sex offenders are generally older than most other types of offenders. Hanson et al. (2002) found the mean age of over 9000 sex offenders to be approximately 36 years, with this figure varying between rapists, child molesters and incest offenders. In Australia the median age of those incarcerated for sexual assault in 2007 was 42 years (Australian Bureau of Statistics 2007).

However evidence also suggests that adolescents commit a sizeable proportion of sexual offences. New Zealand police data indicate that youth under 18 years were responsible for 15% of all sex offences that were reported or registered in New Zealand from the years 2000 to 2005 (Statistics New Zealand 2005; cited in Lambie 2007: 9). Similarly a health survey completed by a random sample of 500 women in New Zealand revealed that one quarter of all the sex offences reported by victims were committed by youth under 18 years (Mullen et al. 1991; cited in Lambie 2007: 9).

Further research from New Zealand suggests that adult sex offenders against children who began offending in their youth are almost twice as likely to reoffend sexually than those who began offending in their adulthood (Bakker et al. 1998). Other findings indicate that most high-risk adult sex offenders will begin offending in their adolescence (Manderville-Norden & Beech 2004).

In Australia and New Zealand the need to involve the family of sexual offenders in the treatment process is being increasingly recognised. For adolescents in particular, being isolated from one's family as a result of sexual offending can jeopardise the young person's ability to address such behaviour through treatment.

Also as it is well documented in the literature that a large proportion of sexual offences are intra-familial, this family involvement is seen to be beneficial to both victims and offenders. Some programs, such as the Sexual Abuse Counselling and Prevention Program in Victoria (see Appendix D) offer treatment to adolescents who sexually offend, as well as victims and the families of offenders. The five adolescent programs referred to in this study are all community based.

Effectiveness of adolescent programs

The New Street Adolescent Service in New South Wales is offered to youth between the ages of 10 and 17 years with sexual offending behaviour. The program treats young people on the basis that their parent/caregiver can be involved in the treatment process, as it is not seen to be developmentally appropriate for adolescents to be treated without this element. A 2006 evaluation of the New Street program found that the majority of participants had been subject to various types of harm themselves, including neglect and exposure to domestic violence (Laing, Mikulsky & Kennaugh 2006). This finding is supportive of the emphasis on family intervention as a key element in addressing sexual offending behaviour amongst young people.

When examining the recidivism rates of participants, authors of the New Street evaluation used a comparison group matched to the treatment group on seven criteria. The comparison group were drawn from young people referred but not offered a service, as the program was full (Laing et al. 2006). Many of the comparison group received treatment elsewhere, however the authors were unable to track this. Unlike most of the studies included in this paper the New Street evaluation included reports of sexual recidivism as well as reconviction data. Follow up periods were between 1 and 6 years.

Within the sample of 100 adolescents in the New Street evaluation it was found that:

- 2.9% (N=1) who completed treatment reoffended sexually
- 14% (N=7) who were referred to but did not receive treatment at New Street reoffended sexually
- 31.3% (N=5) who withdrew from treatment reoffended sexually.

With only 1 out of the 34 offenders who completed treatment reoffending sexually, results are favourable to the effectiveness of the New Street program.

In New Zealand a much larger sample was attainable through a study conducted on three community based treatment programs for adolescents who sexually offend. Lambie (2007) examined client files from the SAFE Network Auckland, WellStop in Wellington and STOP in Christchurch. Within a sample of 682 adolescents the study compared three groups: Treatment Completers, No Treatment and Treatment Dropouts. The sample included female and male adolescents, as well as those with special learning needs. Within an average 4.5-year follow up period, it was found that:

- 2% of Treatment Completers reoffended sexually
- 6% of the No Treatment group reoffended sexually
- 10% of the Dropout group reoffended sexually.

Results indicated that adolescents who completed treatment at any of the three New Zealand programs sexually recidivated at one third of the rate of those who were referred to the programs but did not receive treatment (Lambie 2007). The size of the sample (N=682) lends weight to these findings, which are supportive of treatment programs aimed at young people who sexually offend.

In Victoria the Male Adolescent Program for Positive Sexuality (MAPPS) has been operating since the early 1990s. MAPPS was developed in acknowledgement of the need to treat adolescents before sexual offending behaviour becomes chronic (Curnow, Streker & Williams 1998). An early evaluation was conducted on MAPPS in 1998 and although changes have been implemented to the program since then, the results should still be acknowledged. Reoffending included sexual offences recorded by police and Juvenile Justice Client Information Systems.

Five per cent of the 138 adolescents who entered the MAPPS program from 1993 to 1998 were found to reoffend sexually (Curnow et al. 1998), although the follow up period for this study was not substantial. Without a control group in the evaluation it is difficult to measure the effects of treatment at MAPPS. Treatment completers were compared with treatment

drop-outs (see Appendix B), and the limitations of this method were discussed earlier in this paper.

Generally the findings suggest that young people who completed treatment at any of the above five community based programs in Australia and New Zealand were less likely to reoffend sexually, although limitations in the study designs were noted. Lambie's (2007) evaluation of three New Zealand programs was particularly noteworthy due to its large sample size and adequate follow up period. Interestingly, older youth undergoing treatment for sexual offences were more likely to drop out of treatment programs than younger youth (Lambie 2007). These findings reinforce the need to engage young people in treatment as soon as problem sexual behaviour emerges.

Indigenous programs

In recent years it has been suggested that CBT-based programs have differential treatment outcomes for Indigenous and non-Indigenous offenders. In many Aboriginal communities learning and healing occurs in the presence and at the interest of the group or community, rather than of the individual (Young 2007; Yavu-Kama-Harathunian 2002). This element of Indigenous culture is unlikely to be compatible with contemporary Western methods of treatment.

A Western Australian study found that juvenile Indigenous offenders were more likely to reoffend sexually after receiving custody-based treatment than non-Indigenous juveniles (Allan, Allan, Marshall & Kraszlan 2003). The appropriateness of internationally developed risk assessment tools being utilised for Indigenous Australian sex offenders has also been questioned (Allan, Dawson & Allan 2006).

Similarly, programs in Canada based on Western psychology are seen as being culturally inappropriate for Canadian Aboriginal offenders, as Hylton observes:

> "*because non-Aboriginal programs typically employ non-Aboriginal staff, there is often a knowledge gap and a corresponding lack of trust between the non-Aboriginal service providers and the Aboriginal clients*" (Hylton 2002:81).

Research suggests that Aboriginal offenders who are rehabilitated through the Canadian criminal justice system are more likely to reoffend than non-Aboriginal offenders (Bonta *et al.* 1997; La Prairie 1996). Such findings have been attributed to the policies of rehabilitation programs failing to acknowledge the language, culture, traditions and current life situations of Aboriginal offenders in Canada (Hylton 2002).

In response to such problems program facilitators in Canada have for several years been incorporating holistic elements into treatment programs to address the needs of Indigenous sex offenders. Hollow Water in Canada uses Aboriginal healing circle models to address child sexual assault. This model uses a holistic approach to involve the offenders, victims and the families of both in the treatment process, which encourages Aboriginal sex offenders to take responsibility for their actions (Young 2007).

However there is little reliable evidence available on the effectiveness of such models. A cost benefit analysis performed on the principal healing circle model at Hollow Water revealed that only 2 adult Aboriginal sex offenders, comprising 7% of those who underwent treatment at the program, had reoffended over a ten year period (Couture *et al*. 2001). According to Young (2007), the possible development of a healing circle model in Australia would need to involve a number of specific principals. Among these would be the involvement of the Indigenous community in the development and implementation of the program (Young 2007).

The three New Zealand programs for adolescents who sexually offend described earlier include culturally appropriate components for Maori offenders. It was found that Maori clients in the program emphasised the importance of having Maori therapists to do deliver these components, in order for them to progress more positively in treatment. However Lambie's (2007) study also revealed a lack of sufficiently trained Maori clinicians employed on the programs, as well as a need for improvement in the cultural supervision and training for non-Maori staff working on the programs (Lambie 2007).

Similarly, attracting skilled Indigenous and non-Indigenous staff to work on Australian treatment programs is a challenge, particularly in more remote areas of Australia where the level of education amongst Indigenous people tends to be lower than in the major cities. In the Northern Territory for example, 51% of Indigenous people aged 15 years or over in 2002 had completed a maximum level of year 9 in high school education (Australian Bureau of Statistics 2002). Program facilitators in Alice Springs cannot find qualified Indigenous staff to work on the Indigenous sex offender treatment program and have trouble attracting non-Indigenous skilled staff.

Findings from these evaluations suggest that twelve out of the thirteen programs were effective in reducing sexual recidivism

In Australia there are currently prison based treatment programs operating for Indigenous sex offenders in three states (WA, SA & QLD; see Appendix C). The development of a new program in Australia, Rural New Street Service is currently underway in northern New South Wales. The program is designed to treat Aboriginal children and young people in rural communities with sexually abusive behaviours.

The Rural New Street Service will target:

- families of youth who sexually offend
- whole communities, with considerable service provision to Aboriginal communities by culturally trained staff
- families in rural and regional areas
- Indigenous staff for recruiting & training.

The program is based on the same principles as the New Street Adolescent Service described earlier, but will place particular emphasis on addressing the needs of the families and communities of Aboriginal youth who sexually offend.

It is difficult to determine whether Indigenous-specific programs in Australia are effective, as most have been only recently implemented. To overcome this problem the Rehabilitation Programs Branch (RPB) in South Australia Department for Correctional Services have based the Indigenous sex offender treatment program closely on a Canadian model that has been found to reduce sexual recidivism. The following methods have been adopted to make the Indigenous program in SA more successful:

- Employment and training of Indigenous staff in the RPB.
- Co-development and facilitation of the program by Indigenous and non-Indigenous staff.
- Consultation with Indigenous elders to provide guidance in program delivery.
- Implementing the program within the vicinity of Indigenous communities.
- Involving the families and communities of Indigenous offenders in the treatment process.
- Employing evaluation staff to monitor reoffending and risk factors associated with reoffending.

Future programs that are developed for Indigenous and non-Indigenous offenders should include a monitoring and evaluation process within the program designs.

Conclusion

This study reviewed the evaluation results from eight treatment programs for adults and five treatment programs for adolescents who sexually offend in Australia and New Zealand. Findings from these evaluations suggest that twelve out of the thirteen programs were effective in reducing sexual recidivism.

The methodological limitations in some evaluations were acknowledged. Obtaining comparison groups of untreated sex offenders, as well as matching the variables appropriately with groups of treated offenders is evidently a challenge. Some researchers have overcome this problem by comparing recidivism rates of treated offenders with those predicted by risk assessment tools. It would be beneficial to develop an Australian-specific risk assessment tool similar to the STATIC 99, with probabilities that are based on a sample of sex offenders in Australia.

In terms of the general treatment available, a proportion of sex offenders generally bypass treatment, such as high-risk violent sex offenders and those who categorically deny responsibility of their offences. Such offenders may be more susceptible to extended detention/supervision orders if they are assessed as being at high risk of reoffending upon their release. The development of a community based program for high-risk sex offenders released on bond would help to address such gaps in treatment.

New Zealand treatment programs were found to have positive evaluation outcomes. Evaluations of the two prison based programs, Kia Marama and Te Piriti indicated that they reduced the sexual recidivism rate of offenders by more than half. Maori sex offenders appeared to respond more positively to the program at Te Piriti, with its combination of tikanga Maori and cognitive behavioural/ social learning theory treatment methods. These findings indicate that the incorporation of traditional and holistic forms of treatment is more effective for reducing sexual recidivism amongst Indigenous offenders.

The effectiveness of Indigenous programs in Australia is yet to be determined. It would be beneficial to develop an initiative that would attract Indigenous staff and elders to work on Indigenous sex offender treatment programs, as this has been reported as being an important element in both Australia and New Zealand programs.

Evidence suggested that the three community based programs for adult sex offenders against children in New Zealand were effective in reducing sexual recidivism. The number of community based programs in Australia has increased in recent years, however further evaluation research needs to be conducted in this area. If programs in Australia incorporate an evaluation and monitoring process into program designs, Australia can be in a position to develop best practice guidelines for Statewide services.

Treatment programs designed for young people who sexually offend in Australia and New Zealand were found to have positive outcomes in reducing sexual recidivism. As the literature indicates that high-risk sex offenders tend to begin offending in their adolescence, more emphasis needs to be placed on providing treatment for young people with sexual offending behaviour. The states and territories in Australia that are currently lacking in this area are the Northern Territory, Western Australia and Tasmania.

Finally, past research suggests that a large proportion of sexual abuse that occurs is intra-familial. Therefore the development of future treatment programs for young people who sexually offend should focus on including the families of offenders in the treatment process. This element is seen as an important developmental factor in addressing the problem sexual behaviour of young people, as well as benefiting the families and victims of offenders.

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Appendix A: Evaluation results from treatment programs for adult sex offenders in Australia and New Zealand

Treatment Program	*Sample size*	*No treatment - Sexual recidivism rate (%)*	*Withdrew from program - Sexual recidivism rate (%)*	*Program Completers - Sexual recidivism rate (%)*
CUBIT NSW [1] - sex offenders against adults and children	117	N/A	N/A	8.5%
VIC Sex Offender Programs – sex offenders against adults and children	330	N/A	20% [2]	4%
Western Australian Sex Offender Treatment Unit – sex offenders against adults and children	2165	7.02%	N/A	14.18%
Kia Marama Treatment Program - sex offenders against children	521	21%	N/A	10%
Te Piriti Special Treatment Programme - sex offenders against children	482	21%	N/A	5.47%
SAFE Network Inc, STOP Wellington Inc & STOP Trust Christchurch - sex offenders against children	203	16%	21%	5.2%

Appendix B: Evaluation results from treatment programs for young people who sexually offend in Australia and New Zealand

Treatment Program	*Sample size*	*Comparison (no treatment) - Sexual recidivism rate (%)*	*Withdrew from program - Sexual recidivism rate (%)*	*Program Completers - Sexual recidivism rate (%)*
New Street Adolescent Service (NSW) [3]	100	14%	31.3%	2.9%
Male Adolescent Program for Positive Sexuality (VIC)	138	N/A	3.6%	0.7%
WellStop, SAFE Network & STOP (youth programs) (NZ)	682	6%	10%	2%

[1] The pilot evaluation performed on CUBIT differed from the other evaluations by comparing the recidivism rates of treated offenders with recidivism rates predicted by the STATIC 99 risk assessment tool, therefore the sample in the table only includes those who were treated at CUBIT, with no control. 8.5% of offenders treated at CUBIT reoffended sexually, compared with the expected sexual recidivism rate of 26%.

[2] The evaluation on the SOP program also included those who were removed from the program, who recidivated sexually at 10%.

[3] The New Street evaluation included reports of sexual recidivism as well as reconviction rates.

Appendix C: Adult sex offender treatment programs in Australia

Jurisdiction	*Prison-based*	*Community-based*
Australian Capital Territory	ASOP - Adult Sex Offender Program	ASOP – Adult Sex Offender Program
New South Wales	CUBIT (Custody Based Intensive Treatment) – high risk offenders CORE (CUBIT Outreach) – low risk offenders Custodial Maintenance program – for graduates of CUBIT & CORE	Community Maintenance program Forensic Psychology Services – low risk offenders Cedar Cottage NSW Pre-Trial Diversion of Offenders Program – Child sex offenders Encompas (Catholic Church) Pastoral Counselling Institute (Uniting Church)
Northern Territory	Sex Offender Treatment Program for Indigenous males - Darwin Sex Offender Treatment Program for Indigenous males - Alice Springs	
Queensland	Queensland Corrective Services - MISOP - Medium Intensity HISOP - High Intensity ISOP – Program for low cognitive functioning sexual offenders IMISOP - Indigenous Medium Intensity IHISOP - Indigenous High Intensity	Medium Intensity Sexual Offending Program Sexual Offending Maintenance Program
South Australia	Sex Offender Treatment Program Indigenous Sex Offender Treatment Program	Community Corrections Sex Offender Treatment Program
Tasmania	Sexual Offending Program – for low, moderate & high risk offenders	
Victoria	MMIP - Modular Management Intervention Program Skills Based Intervention Program Maintaining Change program – for graduates of the MMIP	MMIP - Modular Management Intervention Program SBIP - Skills Based Intervention Program for persons with cognitive impairments
Western Australia	Sex Offender Program Indigenous Sex Offender Program Program for intellectually disabled offenders	Community-based Maintenance program Community-based program Community-based program for intellectually disabled offenders S.A.I.F. Program (Safecare)

Adapted from Lievore (2004); Chung et al. (2006); and through consultations with corrections staff in various jurisdictions.

Appendix D: Treatment programs for young people who sexually offend in Australia

Jurisdiction	*Treatment program*
Australian Capital Territory	Triple R – Sex Offender Program for Juveniles
New South Wales	New Pathways (Youth of the Streets) New Street Adolescent Service (NSW Health/Cedar Cottage) Rural New Street (currently being established by HNEAHS for NSW Health) SOP NSW (Dept of Juvenile Justice)
Northern Territory	
Queensland	Griffith Adolescent Forensic Assessment and Treatment Centre (Griffith University) Face-Up Program (Mater Children's Hospital Child Protection Unit)
South Australia	Mary Street Adolescent Sexual Abuse Prevention Program
Tasmania	
Victoria	MAPPS - Male Adolescent Program for Positive Sexuality Sexual Abuse Counselling and Prevention Program (Children's Protection Society)
Western Australia	Safecare Young People's Program

Adapted from Lievore (2004); Chung et al. (2006); and through consultations with corrections departments in various jurisdictions.

Appendix E: New Zealand treatment programs for adults and young people who sexually offend

City	*Prison-based*	*Community-based*
Auckland	Te Piriti Special Treatment Programme – Program for adults convicted of sexual offences against children	
Christchurch	Kia Marama Programme – Program for adults convicted of sexual offences against children	
Auckland, Hamilton & Whangarei		SAFE Network - Adult Program Adult Maori Program Youth Program Maori Youth Program Child Treatment Program
Christchurch		STOP – Children's Program Adolescent Program Adult's Program
Wellington, Palmerston North, Napier, Gisborne, New Plymouth (affiliated)		WellStop – Adult Program Youth Program

Table created through consultations with staff working on various treatment programs in New Zealand.