

ROYAL COMMISSION INTO INSTITUTIONAL  
RESPONSES TO CHILD SEXUAL ABUSE

Public Hearing - Criminal Justice Roundtable  
(Day 2 - Adult sex offender treatment programs)

Hearing Room 2  
Level 17, Governor Macquarie Tower  
Farrer Place, Sydney

On Thursday, 21 April 2016 at 10am

Before

The Chair:	Justice Peter McClellan AM
The Presiding Member:	Justice Jennifer Ann Coate
Commissioner:	Mr Bob Atkinson AO APM

1 THE CHAIR: Good morning. I don't know most of you,  
2 I know some of you, but welcome. We have a couple missing  
3 too. They're not outside?  
4

5 MS SANDERSON: No, Professor Smallbone is running about  
6 ten minutes late.  
7

8 THE CHAIR: We have, as part of the Royal Commission's  
9 obligations, to examine the criminal justice system as it  
10 relates to the sexual abuse of children, but plainly, once  
11 you step into the criminal justice area in relation to  
12 sexual abuse, you end up looking at a broader picture than  
13 just children.  
14

15 To help the six Commissioners come to conclusions  
16 about this, we have split ourselves up and Justice Coate  
17 and Commissioner Atkinson and I have been tasked with  
18 pulling together the Commission's tentative thoughts in  
19 relation to the issues that arise in the criminal justice  
20 area and then all six Commissioners will ultimately come to  
21 consider what we should say.  
22

23 We are ably assisted - should I say ably led - by  
24 Leigh Sanderson who some of you know, probably now all of  
25 you have spoken to her, and the team that she has. Leigh  
26 did a huge amount of work for us in relation to redress and  
27 civil justice and she is responsible for driving the  
28 criminal justice work. The criminal justice component of  
29 our work is a very significant part of our obligations.  
30 That is not to suggest that there aren't equally  
31 significant other parts of our obligations, there are. The  
32 task that we have is a huge task and it's made larger by  
33 the fact that it is a task that requires us to look at the  
34 position in relation to all of the States in Australia.  
35

36 Before we start further, I would just like to  
37 acknowledge the traditional custodians of the land upon  
38 which we meet today, the Gadigal people of the Eora Nation  
39 and pay my respects to their elders past and present.  
40

41 Today of course is a public event, although I don't  
42 see too many members of the public here. However, it is  
43 necessary for me to remind you that it is being  
44 live streamed so that anyone who wants to watch, and many  
45 people do, can look on our website and access the screen  
46 and see what all of you have to say throughout the day.  
47 The cameras, I am told, can be controlled to focus on

1 anyone who is speaking at any particular time. Could I ask  
2 you, though, when you do speak, to try and make sure that  
3 you identify who you are because I am not sure the cameras  
4 will pick up your name in a way that someone at home might  
5 be able to identify who you are.

6  
7 We held our first public roundtable in relation to  
8 criminal justice yesterday and this is the second in the  
9 process and there is more to come. Criminal justice,  
10 of course, has otherwise arisen in a number of our public  
11 inquiries. Inevitably, when you have criminal activity,  
12 you will intersect the police and criminal justice  
13 components of society fairly readily.

14  
15 However, when we come to criminal justice one of the  
16 very significant issues is, firstly, the trial process and  
17 I see Jane Goodman-Delahunty over there. She has, together  
18 with Annie Cossins, done a huge amount of work for us in  
19 relation to a study of juries in sexual assault trials and  
20 in a few weeks time we're going to I think release that  
21 work; is that right, Jane?

22  
23 PROF GOODMAN-DELAHUNTY: I hope so.

24  
25 THE CHAIR: So I do - which will help to inform a lot of  
26 the work we're doing about the trial process and about the  
27 way judges speak to jurors and the study attempts to  
28 identify how ordinary people, jurors, reason and whether  
29 they obey what judges tell them and what the outcomes are  
30 from their reasoning processes.

31  
32 Of course, the second major component in the criminal  
33 justice system, apart from the trial, is the sentencing  
34 process and then this is where you all come in, because  
35 that sentencing process needs to be informed by the work  
36 that can be done in relation to the treatment of offenders  
37 and ultimately, of course, that visits itself upon the  
38 criminal justice system in the continuing detention regimes  
39 which exist in some States.

40  
41 I am familiar with some of the work that has been done  
42 in this area because one of my responsibilities in the  
43 Supreme Court was the hearings in relation to continuing  
44 detention, so I have seen some of the debates that have  
45 occurred about the effectiveness of the process and what  
46 you should do with people, but I, like the other  
47 Commissioners here today, are very much looking forward to

1 what you all have to tell us about this area.

2  
3 I should emphasise today that we are considering  
4 treatment programs for those who have committed sexual  
5 offences as adults. We do have a separate work stream in  
6 relation to children with sexually harmful behaviours and  
7 that work will be separate in our discussions from what  
8 we're looking at today, but that's not to underestimate,  
9 and we don't, the fact that child to child sexual abuse is  
10 a very important topic for us to examine. It is a very  
11 significant component, so far as you can work out, of  
12 offending which now occurs in an institutional context and  
13 it is important for this Royal Commission to ensure that we  
14 address those issues.

15  
16 Those children who offend and get into trouble in that  
17 way, of course, will also intersect the criminal justice  
18 system but in different ways, one hopes, generally to  
19 adults.

20  
21 Today, as you know, we have broken into two separate  
22 parts, if you like. What I want to try and find out from  
23 all of you in each of the relevant jurisdictions, firstly,  
24 is what treatment programs are offered, what the  
25 eligibility rules are to participate in those programs, and  
26 I know that there are actual physical constraints because  
27 of numbers and because of time in incarceration. We would  
28 like to understand the position of each of the States in  
29 relation to that.

30  
31 We would like to know whether the programs that you  
32 conduct are tailored to particular groups, such as or  
33 including Aboriginal and Torres Strait Islander people,  
34 whether you separate out and have separate programs;  
35 whether you have, again, separate approaches to people with  
36 intellectual disability or cognitive impairment. They in  
37 many respects raise very difficult issues for this  
38 Royal Commission but for the community generally in  
39 providing them with an appropriate response in various  
40 areas and we have devoted quite a deal of time, and there's  
41 more time to come, specifically to that group, but we would  
42 like to know whether your treatment programs address those  
43 issues.

44  
45 I suspect I know the answer to this but we would like  
46 to know what you do with someone who denies still that  
47 they've offended and how you approach them, if at all, in

1 the context of any treatment program. We would like to  
2 know about your program structures, how they're organised,  
3 and availability, and also we'd like to know, if you can  
4 tell us, what your take-up rates might be and also what  
5 your drop-out rates might be. Are there many people that  
6 start and stop or do people who start come to the end?  
7

8 Western Australia, unfortunately, can't be with us  
9 today but I think Leigh has a written document from them  
10 which she will read to all of us in due course.  
11

12 As you all will have worked out if you don't know each  
13 other, but looking at the name plates you've probably  
14 worked out that we have operators - can I put it that way -  
15 and academics. That's not being unkind to anyone, is it?  
16 The operators we're going to ask to tell us what you do and  
17 we're going to ask the academics to comment upon what you  
18 do, which is the usual way that academics work, I suppose,  
19 but all done with a view to helping us to understand what  
20 is happening and to see whether we can work out whether we  
21 can help in this area, which is our object in everything  
22 that we do.  
23

24 We, in that context, do understand that there has  
25 already been significant work done in evaluation of  
26 programs. We will find out a bit more about that in the  
27 second part of the session. How good the evaluations are  
28 and how relevant to all of you or each of you in  
29 contemporary circumstances we would like to know.  
30

31 We want to know what the outcomes have been from the  
32 review and evaluation programs. We would like to know  
33 whether there's a contention that any particular program  
34 achieves the best outcomes or whether they're variable. In  
35 other words, we would like to know if there is a  
36 controversy in terms of the programs and whether people  
37 contend that theirs, for whatever reason, is better than  
38 someone else's. We would like to understand the whole  
39 issue about the nature and also the response of individuals  
40 to the programs when provided.  
41

42 Ultimately, of course, our purpose is to see whether  
43 or not this part of the criminal justice system is working  
44 beneficially to help to protect children from abuse within  
45 institutions. But, as I said when I started these short  
46 remarks, it's impossible - we understand that - to separate  
47 out the offenders who happen to have offended in an

1 institutional context from those who might otherwise  
2 offend, but our object, at the end of the day, is to bring  
3 forward recommendations which will help, we trust, children  
4 in institutions to be kept safe.

5  
6 Finally, I guess, in that context, we know a little  
7 bit about the role that treatment plays in decisions to  
8 grant parole to offenders, and, of course, the role it  
9 might have in continuing detention, and, of course, that  
10 visits itself back into the community and also into  
11 institutions.

12  
13 We have here today Louise Coe. Louise, we  
14 specifically want to talk to you. Louise comes from the  
15 Office of the Children's Guardian in New South Wales. We  
16 want to know how all this intersects with, particularly,  
17 Working With Children Check schemes, and so on, and what  
18 decisions are responsibly made in that context, after  
19 someone might have been through one of these systems. But  
20 I think you have been primed to know that that's what we  
21 want to find out.

22  
23 MS COE: Yes.

24  
25 THE CHAIR: Now, we are making a transcript of today's  
26 proceedings. I think the relevant people are sitting above  
27 us, and they can now look down and see who is talking, but  
28 they will be helped by you identifying who it is that is  
29 talking at any particular time.

30  
31 So, welcome. Let's start in to understanding where  
32 everyone is going.

33  
34 Now, I said to Leigh this morning, "Why don't I start  
35 at the other end from where people normally start in  
36 talking to the States", and she said, "No, no, you can't do  
37 that." There is a protocol I have to follow. So we start  
38 with New South Wales. Who is going to tell us what happens  
39 in New South Wales?

40  
41 MS DONALDSON: Hi, my name is Meagan Donaldson. I'm  
42 a senior psychologist in custody-based sex offender  
43 programs for Corrective Services NSW.

44  
45 Corrective Services NSW offers a suite of programs for  
46 offenders convicted of sexual offences. We have  
47 a Preparatory Program, we run treatment programs and also

1 Maintenance Programs. Most of our treatment programs are  
2 run in custody, however, we do provide a community-based  
3 treatment program and also custody and community-based  
4 maintenance programs.  
5

6 If I just speak to our treatment programs, all of our  
7 custody-based treatment programs and our community-based  
8 treatment program are based on a cognitive behavioural  
9 therapy model and also the risk-need-responsivity model of  
10 offender rehabilitation.  
11

12 We provide treatment in a group format, and that's in  
13 an open or a rolling group format, so that rather than have  
14 offenders start and complete at the same time, we have  
15 individual treatment plans for offenders. They work  
16 through the programs at their own pace, and that way we are  
17 able to target treatment needs specific to the individual.  
18

19 All of our programs in custody are also facilitated in  
20 a therapeutic environment. This means that rather than  
21 being in wings with other mainstream offenders, they are  
22 actually housed in a specific wing where we have  
23 psychologists, specially trained custodial staff, and  
24 services and programs officers that support the offenders  
25 participating in the programs within that community. That  
26 way, all of the offenders who are in that environment are  
27 in a treatment program, are working on their own treatment  
28 needs and supporting each other to work on their treatment  
29 needs, but it also provides an opportunity for the  
30 offenders to take what they are learning in the group-based  
31 sessions and put that into practice in the therapeutic  
32 community, practising their relationship skills,  
33 communication skills, how they cope with conflict and some  
34 of the challenges they might experience in that therapeutic  
35 wing.  
36

37 So the programs that we offer in custody are: we have  
38 a Custody-Based Intensive Treatment Program, which is for  
39 moderate-high to high-risk offenders. We have  
40 a CORE Moderate program, which is for those who have been  
41 assessed as a moderate risk of sexual offending. We have  
42 the Self-Regulation Program: Sexual Offenders, so this is  
43 a moderate-to-high-intensity program for men who have an  
44 intellectual disability or a cognitive impairment that  
45 might impact on their participation in one of the other  
46 treatment programs.  
47

1           We also offer the Deniers program. This program isn't  
2 one of our rolling programs. It is actually run on a needs  
3 basis. So when we actually have enough offenders who  
4 categorically deny their offence, we run that program when  
5 there is enough need. So currently, that is approximately  
6 every 12 to 18 months, in custody.

7  
8           We also then have our Community-Based Treatment  
9 Program, so this is facilitated at an office at Surry  
10 Hills, and a Maintenance Program, which is facilitated out  
11 of the same area.

12  
13           If I think about the content - I'm not sure if you  
14 want the content of the --

15  
16 THE CHAIR: Can I just ask you a couple of questions first  
17 of all?

18  
19 MS DONALDSON: Certainly.

20  
21 THE CHAIR: Are the programs offered in the one prison or  
22 are they offered in different facilities?

23  
24 MS DONALDSON: Our custody-based sex offender programs is  
25 a State-wide process. So for the eligibility, we consider  
26 that anyone who has a current or historical conviction for  
27 a sexual offence is eligible to refer to our programs.  
28 Once we have received the referrals we undertake the  
29 necessary static and dynamic risk assessments and determine  
30 who might be suitable for which programs, based on their  
31 level of risk, their treatment need, and also those  
32 responsivity issues. So we are a State-wide referral  
33 process, but the programs are currently located at MSPC,  
34 which is at Long Bay Correctional Centre, and also at  
35 Cessnock Correctional Centre as well.

36  
37 THE CHAIR: And what is the minimum period of  
38 incarceration that a prisoner must have received before  
39 they will be eligible for a program?

40  
41 MS DONALDSON: I'm not sure of the minimum. We have an  
42 ideal, so an ideal would be an 18-month custodial sentence.  
43 That would allow time for the offender to have the  
44 appropriate assessments conducted and time to participate  
45 in our programs.

46  
47           I didn't mention the treatment duration. So our



1 high-intensity treatment program is a six-to-10-month  
2 program; our moderate-intensity program is  
3 a six-to-eight-month program; and our Self-Regulation  
4 Program is a 12-to-18-month program, and this is just  
5 because the tasks and modules of the program are broken  
6 down into smaller components for the men with an  
7 intellectual disability. So we need time for the offenders  
8 to be assessed and then also for them to participate in the  
9 program.

10  
11 Particularly for our high-risk offenders, it is ideal  
12 that they participate in a Maintenance Program as well,  
13 where they have the opportunity to practise the skills that  
14 they have learnt in a less-restrictive environment, so  
15 outside of the therapeutic environment and back when they  
16 are housed in other wings with other offenders as well.

17  
18 THE CHAIR: And do you have drop-out rates?

19  
20 MS DONALDSON: Yes. Historically, the drop-out rates for  
21 CUBIT have been quite high. So prior to 2005 it was at  
22 about 30 per cent. Since we have introduced the rolling or  
23 the open-group format, for the 2014/15 financial year our  
24 completion rate was 97.7 per cent for our CUBIT programs.

25  
26 THE CHAIR: Why did it change?

27  
28 MS DONALDSON: With the support of research, and  
29 international research, around best practice and that  
30 rolling groups allow, again, for individuals to participate  
31 at their own pace. So those who may have been unmotivated  
32 may have dropped out earlier. Rolling groups allow for  
33 suspensions or kind of a time out of the program, rather  
34 than a complete discharge. But we also changed to a more  
35 positive-psychology, strength-based approach as well, and  
36 a less-confrontational approach to treatment, which meant  
37 offenders were more engaged and more motivated within the  
38 programs, and so all of that change occurred around 2005.

39  
40 THE CHAIR: And your program now is called what?

41  
42 MS DONALDSON: We have multiple programs. We have the  
43 Custody-Based Intensive Treatment, which is our high-risk  
44 high-intensity treatment program, so that's our main  
45 program.

46  
47 THE CHAIR: What do you call that?

1  
2 MS DONALDSON: CUBIT.  
3  
4 THE CHAIR: CUBIT.  
5  
6 MS DONALDSON: Yes, sorry, CUBIT.  
7  
8 THE CHAIR: And you also have other programs, called --  
9  
10 MS DONALDSON: We have CORE Moderate, so that's the CUBIT  
11 Outreach. We have renamed it to CORE Moderate just to  
12 capture that it is a moderate-intensity program. The  
13 Self-Regulation Program: Sexual Offending - the acronym  
14 for that is SRP:SO. And then the Deniers program.  
15  
16 THE CHAIR: Right. And they are all prison-based or  
17 custodial based?  
18  
19 MS DONALDSON: They are all prison or custodial based.  
20  
21 THE CHAIR: Now, once released, what do you offer?  
22  
23 MS DONALDSON: We offer community-based Maintenance for  
24 those offenders who are at a moderate or high risk of  
25 sexual re-offending. So those sessions occur again in our  
26 office at Surry Hills. Maintenance is provided again in a  
27 group base, so it is often graduates from the treatment  
28 program in custody that are participating in the  
29 Maintenance Program in the community.  
30  
31 Most offenders participate on a weekly basis in that  
32 program, and most of them for the duration of the time that  
33 they are under supervision with Corrective Services in the  
34 community.  
35  
36 THE CHAIR: So when they are on parole?  
37  
38 MS DONALDSON: When they are on parole, yes.  
39  
40 THE CHAIR: Now, there used to be community-based full  
41 treatment programs.  
42  
43 MS DONALDSON: There still are.  
44  
45 THE CHAIR: Run by your organisation?  
46  
47 MS DONALDSON: Yes, run by Corrective Services at Forensic

1 Psychology Services. So the community treatment program  
2 runs very similar to the custody-based treatment programs,  
3 though they are for a lower-risk offender, for the  
4 moderate-risk offenders. And that is just because the  
5 treatment can't be provided at a high-enough intensity for  
6 our high-risk offenders in the community.  
7

8 So our community treatment program is run on a weekly  
9 basis as well. Most offenders participate in that program  
10 for between six to 12 months, after which they could  
11 participate in the community-based Maintenance Program as  
12 well.  
13

14 THE CHAIR: And are these people who have been in  
15 full-time custody?  
16

17 MS DONALDSON: We do have occasions where an offender may  
18 not have completed the treatment program in custody, and  
19 providing he has been released to a metropolitan area and  
20 can access the service, he may be able to continue  
21 treatment in the community, providing he's been released by  
22 the State Parole Authority.  
23

24 THE CHAIR: Who else participates in these full-time  
25 programs outside of the prison system?  
26

27 MS DONALDSON: It would be offenders who are serving  
28 a community supervision order, supervised by Corrective  
29 Services NSW.  
30

31 THE CHAIR: And are there many people in this program  
32 outside of the prison system?  
33

34 MS DONALDSON: If I can actually just have a look at my  
35 participation numbers, so for the last financial year we  
36 had 81 offenders participating in the community treatment  
37 program. We had 58 of those actually complete the program  
38 within that time frame. It's also a rolling group, which  
39 is why they don't all start and finish within that one  
40 financial year. Again, the completion rate for that  
41 program was 94 per cent.  
42

43 THE CHAIR: Do you have numbers there for the number  
44 within prison in the last financial year who were being  
45 treated?  
46

47 MS DONALDSON: Yes. I have it broken down by program. In

1 our CUBIT program, our high-intensity program, we had  
2 85 participants in the last financial year and 43 of those  
3 completed. Again, because it is a rolling program, those  
4 who start the program may not finish within the same  
5 financial year.

6  
7 In our CORE Moderate program we had 52 participants in  
8 the year and 22 of those completed, with a completion rate  
9 of 100 per cent.

10  
11 We also had the Self-Regulation Program. Because this  
12 program is a 12-to-18-month program the numbers are lower.  
13 We had 13 participants and we actually had six of those  
14 complete, and that was a completion rate of 100 per cent.

15  
16 For the Deniers Program, we commenced the program  
17 in February of 2014, so we had 10 offenders participating  
18 in that Deniers Program, and they all actually completed in  
19 the August of 2015. So whilst they aren't reported for the  
20 financial year, all 10 of those offenders completed the  
21 program.

22  
23 THE CHAIR: All right. Thank you.

24  
25 Who is going to tell us about Victoria?

26  
27 MS BRADEN: I might start. I'm the manager of the  
28 Specialised Offender Assessment & Treatment Service, known  
29 as SOATS. Then perhaps Joe Mollica, who is the deputy  
30 manager of the treatment team for Corrections Victoria,  
31 might contribute as well.

32  
33 So, very similarly to New South Wales, we operate  
34 under a centralised service delivery model across both  
35 prison and community for the State of Victoria. So,  
36 basically, any offender who is convicted of a sexual  
37 offence who goes through the prison or Community  
38 Corrections is referred through to us. Our core business  
39 is assessment and treatment of all those sexual offenders.

40  
41 We also include referrals that might be where there is  
42 not a sexual conviction but there might be a sexual  
43 motivation or sexual element to the offence. We are also  
44 referred stalkers and arsonists to consider whether there  
45 was a sexual element associated with that offending, so  
46 that we kind of capture those ones that may have had  
47 reasons why the particular sexual offence was not actually

1 progressed through the courts.

2  
3 Our core business, as I said, is assessment and  
4 treatment, so we use specialised assessment tools to  
5 determine the risk level and the treatment needs of  
6 offenders.

7  
8 So based on those outcomes of assessment and treatment  
9 needs we will make a recommendation for a treatment pathway  
10 that is commensurate to that risk and treatment need. So  
11 if someone is assessed as high-risk and has high-level and  
12 complex treatment needs, they will be referred through to  
13 our high-end treatment programs.

14  
15 So we have, again, a suite of programs, similar to  
16 New South Wales, which is based on the cognitive behaviour  
17 therapy approach. But we do have built in some other  
18 elements in our treatment programs to assist offenders  
19 being able to commence and complete treatment programs  
20 where there are specific responsivity matters that might be  
21 relevant for particular offenders.

22  
23 We also have a Treatment Readiness Program that  
24 assists where offenders may have some reluctance or  
25 resistance to actually engaging in full offence-specific  
26 treatment, so we will use that six-week treatment program  
27 to assist in facilitating to be able to move them through  
28 to the more offence-specific programs.

29  
30 We have a Better Lives Program, which has two  
31 versions, which is our moderate-high- and high-risk  
32 offenders, and we also provide that to our  
33 moderate-low-risk offenders. They just have different  
34 duration and different dosage attached to those particular  
35 risk groups.

36  
37 We have our Treatment Readiness Program. We also  
38 provide a specific treatment program for offenders with  
39 a registered intellectual disability or a confirmed  
40 acquired brain injury or a suspected ABI or are somewhere  
41 along the spectrum of cognitive impairment. So we deliver  
42 a joint treatment program which is delivered in prison with  
43 both a private prison provider, Department of Human  
44 Services and Corrections Victoria, and that is a dedicated  
45 therapeutic unit, located within the prison, where those  
46 guys who are detected with an intellectual impairment are  
47 accommodated, and we provide the offence-specific work for

1 those offenders in that particular unit. They also have  
2 a range of other offence-related programs and behaviour  
3 management programs that assist with managing the  
4 complexity of their presentations and their level of  
5 cognitive impairment to be able to progress them through  
6 the system.

7  
8 We also have a dialectical behaviour therapy - DBT -  
9 program, which is an offence-related program; it is not  
10 offence specific. We use that more so for our  
11 post-sentence sex offenders who are subject to continued  
12 supervision or detention orders. That is about assisting  
13 in their behaviour management of the complex presentations,  
14 co-morbid presentations that those offenders tend to  
15 present with in relation to managing their behaviour.

16  
17 We also run Maintenance programs in the community as  
18 well. We don't run those in the prisons, because it's an  
19 unrealistic environment to test the treatment gains that  
20 are made, so that's best addressed and managed whilst  
21 subject to, say, a parole order or a community supervision  
22 order.

23  
24 I might hand over to Joe to speak a little bit more  
25 about the actual therapeutic component of the treatment  
26 program.

27  
28 MR MOLLICA: Sure. We used to run a program called the  
29 Modular Management Intervention Program, which again was  
30 CBT based. It had kind of elements of relapse prevention.

31  
32 In 2013 we had a revision of that program and we have  
33 moved to the Better Lives Program, which is still cognitive  
34 behaviourally based. We have put in elements of the Good  
35 Lives Model and self-regulation theory, and it is  
36 positive-psychology based. So rather than the deficits  
37 model that we had before, we've moved to positive  
38 psychology.

39  
40 We are finding - it has only been going probably 15  
41 months, now - our offenders are a lot more engaged. It is  
42 too early to tell about the outcomes, but we are kind of  
43 forecasting that the uptake and the transition through the  
44 programs is more therapeutically sound for our cohort.

45  
46 THE CHAIR: What brought you to make the change? Were you  
47 unhappy with what was happening before?

1  
2 MR MOLLICA: We revised our program in 2000 and we moved  
3 to a new model, and then 10 years later we reviewed it  
4 again. We had an external consultant, internationally  
5 recognised, who did a literature search around the world  
6 and, based on that kind of research, we decided to move our  
7 program a little bit more towards positive psychology. So  
8 we're not confrontational at all; we are very offender  
9 focused and assisting them to move forward in their lives  
10 in a better way. Yes, so it is really based on more  
11 current research.

12  
13 THE CHAIR: But had you identified problems with what you  
14 were doing before or a lack of success in effective  
15 treatment?

16  
17 MR MOLLICA: We just felt that engagement wasn't as good  
18 as it could have been. There was kind of an "us and them"  
19 mentality, which wasn't really useful in our therapeutic  
20 program.

21  
22 In terms of outcomes, we are at not really clear at  
23 this point, because we've only been doing it for 15 months,  
24 but intuitively, and the feedback I'm getting from our  
25 clinicians is, it is a much better working style,  
26 particularly given that we are in a therapeutic community  
27 at one of the prisons that we work out of, and we are  
28 trying to develop culture change there as well, engaging  
29 more positively with the offenders.

30  
31 THE CHAIR: What are your numbers - do you know?

32  
33 MS BRADEN: As in participants?

34  
35 THE CHAIR: Yes.

36  
37 MS BRADEN: We have 110 prison completions per year. We  
38 have a 92 per cent completion rate in prisons. We have  
39 156 completions in community, and the completion rate is  
40 around about 85 per cent. So it's a little bit lower in  
41 the community, but you have more challenges in relation to  
42 transient offenders who might change address, so they might  
43 move to another location or they might be returned to  
44 custody for a breach of their order. So you have more  
45 variables that will connect to whether that person is able  
46 to complete or not.

47

1 THE CHAIR: And what about time in prison - are there  
2 limitations on those who can go into programs because of  
3 the length of their sentence?  
4

5 MS BRADEN: Yes, similarly to New South Wales, it is  
6 a preferred 18-month sentence. However, if someone does  
7 have a lesser sentence - so our aim is to assess and have  
8 someone in treatment in community within three to five  
9 months; but in prison we do back-end treatment currently,  
10 so we like to have offenders being able to engage at that  
11 earlier point, but the 18-month sentence is more  
12 preferable, by the time they go through the system, in  
13 terms of their prison placement, our assessments and having  
14 some time to actually go through Treatment Readiness and  
15 address any responsivity issues that might be present, any  
16 acute mental health illness and all those kinds of factors,  
17 to be able to actually successfully complete the treatment  
18 program.  
19

20 So there is the element of, where you do have short  
21 sentences, that does affect the ability of us to be able to  
22 engage the offender.  
23

24 We work off a basic principle of an offender needs to  
25 be ready, willing and able. So ready - that they have  
26 sufficient time in their sentence and they are in the right  
27 time of their sentence; willing, that they are consenting  
28 and wanting to participate; and able, that there are no  
29 responsivity issues that are likely to impact or impede  
30 their ability to commence and complete the program, because  
31 we don't want drop-outs because we know that that increases  
32 their risk of likelihood of re-offending.  
33

34 So we work off that principle and we put some  
35 structures around supporting that principle to try to  
36 assist with responsivity or, where we can, around  
37 motivation. So if they are refusing, we actually do  
38 a three-stage process of motivational interviewing, a whole  
39 lot of other kinds of mechanisms to try to shift the  
40 offender to be able to and want to engage in treatment,  
41 because if they want to engage they are more likely to  
42 actually gain positively from that treatment process.  
43

44 THE CHAIR: So you don't have a deniers program?  
45

46 MS BRADEN: We don't have a deniers separate program, but  
47 we actually have deniers within our mainstream groups. We



1 just take a little bit of a different approach to how you  
2 frame their participation.

3  
4 Denial is on a spectrum - so you can have categorical  
5 denial through to, "Yes, I was there, but it was  
6 consensual". So we can work with that aspect much easier  
7 than the categorical denial. So we just frame that in the  
8 way of, rather than talking about the offence specifically,  
9 "What were the situations leading up to the circumstances  
10 where you were charged and convicted of this offence?" So  
11 you can shift past that point of, you know, getting the  
12 kind of admission of the offender, because you still want  
13 to get them to engage to make those changes in a positive  
14 way to be able to be offence-free post treatment and post  
15 release to the community.

16  
17 THE CHAIR: Can I inquire generally, do you all have  
18 a structured arrangement whereby you talk to each other  
19 about your individual programs?

20  
21 MS BRADEN: We are all part of a National Working Party  
22 under each jurisdiction and we meet annually. We have  
23 about 10 commitments or eight commitments per year, which  
24 is about sharing information, making sure our programs all  
25 measure up kind of similarly to each other. We share  
26 research, we participate in cross-jurisdictional research  
27 so that we're all working as a nation, really, in line with  
28 what best practice is and what our learnings have been from  
29 each jurisdiction. We share that information and we  
30 participate in kind of high-level projects that contribute  
31 to the research or furthering of treatment and outcomes and  
32 community safety.

33  
34 THE CHAIR: We will find out when we get to the end of  
35 this, but I have an impression that, nevertheless, you do,  
36 or you will do, different things; is that right?

37  
38 MS BRADEN: There are some slight variations. So what we  
39 might call "Treatment Readiness" is a "Preparatory  
40 Program", and it might have a little bit of a different  
41 focus, but the principles of how we work are based on the  
42 best practice principles, which we all have signed off on  
43 as jurisdictions. So we know that the presence of certain  
44 elements of a treatment program and how you set up your  
45 service delivery models, the staff training, all those  
46 kinds of elements - if you have those present in your  
47 system, research tells us you are more likely to have

1 better outcomes than not. So we adhere to those principles  
2 as jurisdictions and they are endorsed at high-level  
3 government areas for us. So that's how we kind of work  
4 together as a group across those mainstream principles,  
5 with some variations based on our jurisdictional needs or  
6 profile.

7  
8 THE CHAIR: Well, you may have gathered that that pleases  
9 us to hear, greatly. A true cooperation between State  
10 instrumentalities is very important in many areas.

11  
12 Ashley Phelan, can you tell us about Queensland?

13  
14 MR PHELAN: Yes, I am the acting manager of the Offender  
15 Interventions Unit, Queensland Corrective Services.  
16 I mirror New South Wales's and Victoria's models. We do  
17 CBT, RNA and also a strength-focused practice around what  
18 we call New Futures.

19  
20 We offer a suite of programs both in custody and the  
21 community. We have a Preparatory Program, again which is  
22 a readiness program for our main interventions. We have  
23 our Medium Intensity Program, which can range in  
24 flexibility from 76 hours to 180 hours worth of treatment,  
25 but we can extend that out, if need be. We have had  
26 offenders do 200 hours through the Medium Intensity  
27 Program.

28  
29 We have our High Intensity Program which goes from  
30 9 to 12 months, which is 300 to 350 hours. We have  
31 a Maintenance Program, which is every week for 12 weeks.  
32 Again, we roll that program, so if you need to benefit you  
33 can stay in the program longer, and you can do the program  
34 multiple times. It is a Maintenance Program; it is  
35 a life-long commitment for change.

36  
37 We have an adapted program for intellectually and  
38 cognitively impaired called the Inclusion Program, and we  
39 have an adapted or a culturally appropriate sex offender  
40 program for indigenous males that we run in the Far North.

41  
42 We run all of those programs within custody. Our  
43 primary location is in Brisbane, but we do operate these  
44 programs throughout most of our correctional centres.

45  
46 In the community we run our Medium Intensity Programs,  
47 our Preparatory Programs, and in Townsville we have

1 a Maintenance Program.

2  
3 As to eligibility, any sex offender who has been  
4 convicted of or has committed a motivated sexual offence is  
5 eligible. We have no barriers to entry for denial. We  
6 work with denials, very much in the Victorian model. The  
7 only exclusion criteria would be categorical denial, where  
8 we can't find anything to work with, and we will actually  
9 look at other methodologies to manage the categorical  
10 deniers.

11  
12 We have between 80 to 100 sexual offenders in a  
13 program throughout our system at any one time, and that can  
14 range from 350 to 450 program participants throughout the  
15 year.

16  
17 Let me think of what else we have - so CBT, RNA, we  
18 work to our strengths process.

19  
20 We view the programs that they are not a cure, they  
21 are an important component of an ongoing intervention, a  
22 larger intervention which can also include supervision as  
23 well as motivating offenders to seek out some of their own  
24 support - it could be around drugs and alcohol, it could be  
25 around their mental health, their physical health. So we  
26 see this as an actual lifetime worth of intervention, not  
27 just something that happens within the program itself.

28  
29 So a great deal of our work is shared through all the  
30 jurisdictions, and I think that has been driven from the  
31 National Working Party and the close connections that the  
32 jurisdictions actually have with one another.

33  
34 THE CHAIR: Western Australia is next. Leigh, can you  
35 tell us what they have to say?

36  
37 MS SANDERSON: I am thinking, now, judge, that maybe some  
38 of the other people here know more about Western Australia  
39 than I do, if everyone is going to the national meetings,  
40 but this was a short summary that we prepared based on  
41 documents that we have obtained from Western Australia, and  
42 Western Australian officials were able to review the  
43 document and confirm that it was accurate with a couple of  
44 changes.

45  
46 So Western Australia offers a number of programs in  
47 prison. There is the Intensive Sex Offending Treatment

1 Program for high-risk male sex offenders. There is the  
2 Medium Intensity Sex Offender Program for medium-risk male  
3 sex offenders.  
4

5 There is a Good Roads Aboriginal Sex Offender Program  
6 for Aboriginal Men, a Sex Offending Deniers Program for  
7 those who categorically deny committing sexual offences and  
8 the Sex Offending Intellectual Disability Program for  
9 intellectually disabled male sex offenders. They also  
10 offer three programs in the community. There is the  
11 community based sex offender treatment program for medium  
12 to high-risk sex offenders.  
13

14 There is a community based maintenance program  
15 designed to maintain treatment gains of high-need sex  
16 offenders in the community and the community based  
17 intervention CBI sex-offender program for the sex offender  
18 cohort, with content to suit the specific psycho-education  
19 needs of that group. I also note that individual  
20 psychological counselling is provided to sex offenders as  
21 required.  
22

23 In terms of eligibility for the programs, all sex  
24 offenders of adult and child victims serving an effective  
25 sentence of greater than six months are assessed for their  
26 treatment needs by qualified assessors generally within  
27 28 days of sentencing. The exclusion criteria for a  
28 program typically include unstable or unmanaged mental  
29 health conditions, medical conditions, lack of capacity to  
30 understand program content, significant language barriers,  
31 if they're appealing their conviction or if they refuse to  
32 participate.  
33

34 In terms of programs tailored to particular groups of  
35 offenders, there is the Good Roads Aboriginal Sex Offender  
36 Program for Aboriginal Men, the Sex Offending Deniers  
37 Program for those who deny committing sexual offences and  
38 the Sex Offending Intellectual Disability Program for the  
39 intellectually disabled male sex offenders.  
40

41 In terms of program structure, Western Australia has  
42 advised that the core principles of the Marshall Model  
43 underpin their sex offender treatment programs and that  
44 these principles aim to improve skills and address the  
45 factors known to be associated with the risk of  
46 re-offending, but each program differs in terms of hours  
47 and content.

1  
2           The intensive program addresses the following domains:  
3 life history, disclosure and life's maps, thinking,  
4 feeling, unhelpful thinking, core beliefs, schemas (within  
5 a CBT framework), skill building role plays, background  
6 factors, immediate factors, decision chains, risk factors,  
7 warning signs, self esteem, coping, communication, empathy,  
8 attachment and intimacy, jealousy and loneliness,  
9 unhealthy sexuality and goals and plans, self-management  
10 plans, support and future plans. There are some similar  
11 factors for the medium and deniers program but they're  
12 perhaps a bit narrower.

13  
14           In terms of program availability and take-up rates,  
15 we have some information provided on the number of  
16 prisoners in Western Australian prisons for child sexual  
17 offending and for 2014-2015 they had 309 child sex  
18 offenders of whom 49 were registered for their sex  
19 offending programs, which is a percentage of 15.9 per cent  
20 of offenders were registered for a program.

21  
22 THE CHAIR:   South Australia. Who is going to talk?

23  
24 DR PHARO:    I am Henry Pharo, Director of  
25 Rehabilitation Services and I am accompanied by  
26 Vanessa Swan, Executive Director of Offender Development as  
27 well.

28  
29           In South Australia we have two sex offender programs  
30 that we run in prison, the Sexual Behaviours Clinic, so the  
31 SBC is the acronym, and that's our main program, and then  
32 we also have the SBC-me which is a program designed for  
33 offenders with cognitive deficits, so special needs  
34 offenders. The program runs for approximately 12 months,  
35 that's the SBC program, and the SBC-me program runs for a  
36 longer duration, approximately 18 months.

37  
38           Those individuals are eligible for the program based  
39 on their offending types, so people who have been convicted  
40 of a sex offence or an offence in which there's a sexually  
41 motivated component to that, and also we do have some  
42 individuals who maybe display highly sexualised behaviours  
43 during incarceration and they may get referred for an  
44 assessment for the program as well.

45  
46           Typically, offenders are assessed if they have a  
47 sentence of 12 months or greater. Essentially, that means

1 that they have enough time to be assessed and placed on the  
2 program before the expiry of their order. We accept people  
3 into the program based on an assessment of their risk, so  
4 whether they're either moderate or high risk of  
5 re-offending based on static and dynamic respecters.  
6 Low-risk offenders are referred to a community program  
7 which is operated by SA Health and that is called  
8 Owenia House, but it operates under a very similar model  
9 which is a CBT based program based on the responsivity  
10 model.

11  
12 In our program we accept both child sex offenders, so  
13 offenders who have committed their offence against  
14 children, and also offenders who have committed their  
15 offence against an adult. We do place both of those on the  
16 same program, although there is a caveat there in that the  
17 majority of our participants are placed under protective  
18 custody and we don't mix protectees and mainstream  
19 prisoners, so it means that the number of adult sex  
20 offenders are often in the mainstream portion of the  
21 prison, so they're less likely to receive a program than  
22 child sex offenders. We also include deniers in the  
23 program and we place them in the same program as people who  
24 admit their offending as well.

25  
26 The program lasts for approximately nine months but we  
27 offer a 12-month window because there is pre-program work  
28 that happens beforehand in terms of addressing motivational  
29 factors and things like that and that is also post-program  
30 work, so writing up of reports, and I think most  
31 importantly it really touches to what Ashley was saying as  
32 well, a thorough handover and ongoing contact with  
33 community corrections as well to ensure that there's really  
34 solid case management practices in place for these people  
35 once they are released back into the community as well.

36  
37 The only other thing I would add is that our current  
38 model is that we have both moderate and high-risk offenders  
39 placed in the same program. However, we are reviewing that  
40 at the moment with a look to adopt a similar approach that  
41 the other jurisdictions have which is to introduce a  
42 moderate intensity program for moderate risk offenders and  
43 then a separate high intensity program for high-risk  
44 offenders.

45  
46 MS SWAN: I would like to add to what Henry has said.  
47 I am Vanessa Swan, Executive Director Offender Development

1 in South Australia. As Henry and I think Ashley have said,  
2 we place a great deal of importance on our programs but  
3 equally, we place a great deal of importance in terms of  
4 our community supervision and the re-integration of these  
5 offenders, because we know from the literature that  
6 treatment programs alone have a degree of success,  
7 but treatment programs within a broader system of  
8 re-integration are much more effective.

9  
10 In terms of that, as Henry has indicated, our handover  
11 to community corrections, our support of our community  
12 corrections staff in regard to being aware of risk factors  
13 that they need to be aware of, but also the significant  
14 importance of supporting these offenders to have  
15 constructive activity, meaningful relationships, employment  
16 wherever possible, are very protective in terms of  
17 re-offending.

18  
19 We don't put all our eggs in the treatment basket, we  
20 we put quite a number of them there, but we also make sure  
21 that what we do in the release environment is very  
22 important. In keeping with that we fund through a grant,  
23 an NTO, a non-government organisation in South Australia  
24 too. They are trialling a Circles of Support and  
25 Accountability Program which is modelled on Canadian  
26 examples and also in England. There is still not  
27 conclusive evidence but there is some evidence to say that  
28 some of these approaches are quite effective.

29  
30 That is about putting volunteers around sex offenders  
31 who are also supporters, through clinical staff and staff  
32 with experience, to ensure these people have regular social  
33 interaction and contact. The idea that they become very  
34 marginalised and isolated within society, which we know  
35 will increase their risk of recidivism, we attempt to  
36 reduce the likelihood of that.

37  
38 THE CHAIR: It is something you are offering to sex  
39 offenders as opposed to other offenders when released; is  
40 that right?

41  
42 MS SWAN: Yes, that's correct.

43  
44 THE CHAIR: Do the other States that we have spoken to so  
45 far have the same approach to those who are released?

46  
47 MS BRADEN: Melissa Braden, Victoria. In Victoria we have

1 what we call support and awareness groups. It is based on  
2 the COSA model. However, it is one that relies not on  
3 volunteers within the community. It is actually serviced  
4 and managed through Corrections Victoria. Towards the end  
5 of the treatment program an offender will be asked if they  
6 want to participate in the support and awareness group.  
7 They are to nominate certain support persons that they want  
8 to form part of the group. That can be family, friends, it  
9 might be support agencies, whoever might be a supportive  
10 and protective person for part of their release. We  
11 contact those support and awareness group nominated people  
12 and we explain what the program is about. If they wish to  
13 participate we then provide a community forum for them  
14 where we actually have a three-hour session explaining the  
15 processes of what has occurred for treatment and part of  
16 their sentence for that particular person, be it their son  
17 or whoever.

18  
19 If they then wish to continue on with the process, we  
20 facilitate a support and awareness group meeting with the  
21 prisoner and those support people within the prison, where  
22 the prisoner actually speaks to his new understanding of  
23 why he has come from a non-offending to an offending place  
24 in his life, what were the factors that contributed to  
25 that, what are the signals and signs that those other  
26 support and awareness group members need to be aware of  
27 when he's released into the community.

28  
29 You are actually creating a protective group for that  
30 offender post being in the community similar to the COSA.  
31 We do screen, partially, the support and awareness group  
32 members so they can't be a victim of the offending, they  
33 can't be co-offenders, and we do work on the level of  
34 collusion that might be present within that relationship.  
35 When that offender is released, if they're released to  
36 parole, that support and awareness group continues with  
37 them into part of their parole reporting requirements and  
38 maintains an extra protective factor whilst they're in the  
39 community on top of the minimal supervision whilst under a  
40 community corrections order.

41  
42 THE CHAIR: Andrew, what happens in Tasmania?

43  
44 MR VERDOUW: Andrew Verdouw, Tasmania Prison Service.  
45 In terms of the community --

46  
47 THE CHAIR: No, start by telling us what you do yourself.



1 Tell us about the whole thing.

2

3 MR VERDOUW: I am sorry, I thought we were following from  
4 Victoria. Thank you very much. Tasmania is a unique  
5 situation in that we are a very small jurisdiction. We  
6 gave you data that tells you that 256 or around 250 people  
7 have entered prison for sexual offences since 2010 and when  
8 I look back to 2004, I think it was 356. With such a small  
9 jurisdiction it is really difficult to do the research and  
10 to check our practice, so the approach we've adopted is  
11 that we rely and we seek support from the larger States and  
12 we have certainly worked quite closely with Queensland in  
13 recent times and more recently with New South Wales.

14

15 We are also proceeding that work delivery with  
16 Victoria and are particularly keen on some of their work  
17 around case management and certainly will be looking at  
18 doing further work there.

19

20 You have asked what sort of programs we run. We only  
21 have the one program. It is the New Directions program,  
22 currently based on the Queensland model, and we seek  
23 clinical supervision from - hopefully I can mention the  
24 gentleman, Mr Jayson Ware. We do that, again, because we  
25 don't have the capacity to have people in positions to do  
26 research. We need to seek support from larger  
27 jurisdictions.

28

29 THE CHAIR: How long does your program take?

30

31 MR VERDOUW: Our program, again, is around six to 12  
32 months, depending on the static --

33

34 THE CHAIR: Is it a rolling program?

35

36 MR VERDOUW: It is a rolling, open program, again based on  
37 the Queensland model.

38

39 THE CHAIR: Is it offered only to prisoners who will be  
40 there for more than 12 months, or how does it work?

41

42 MR VERDOUW: We actually have a nine month cut off from  
43 the conclusion of all court proceedings, so if somebody is  
44 appealing, of course we can't actually invite them on to  
45 the program. They need nine months remaining on their  
46 sentence for --

47

1 THE CHAIR: So if the appeal takes six months to  
2 determine - maybe - and your sentence is 12 months, you're  
3 out.  
4

5 MR VERDOUW: It makes it very difficult for us to include  
6 them in treatment, yes.  
7

8 THE CHAIR: What about community based treatment?  
9

10 MR VERDOUW: All community based treatment is administered  
11 as individual case management and given again that we have  
12 small numbers under court supervision, either through  
13 parole or probation, we have no capacity to run any group  
14 type work.  
15

16 THE CHAIR: If an offender by reason of circumstances of  
17 their sentence and appeal processes misses out in prison,  
18 can they access a full program outside the prison?  
19

20 MR VERDOUW: No, they cannot.  
21

22 THE CHAIR: What happens for them? Nothing?  
23

24 MR VERDOUW: Basically, there are no supervision  
25 requirements. Once they've served their sentence, there is  
26 no support or capacity. There are some people that do  
27 participate in private treatment. I am aware of that  
28 anecdotally but I can't give you data.  
29

30 THE CHAIR: Is it relevant to any parole release decision  
31 that someone has or has not had treatment?  
32

33 MR VERDOUW: You may be aware that recently the  
34 Tasmanian Government has introduced legislation, or it has  
35 been passed, regarding encouraging inmates to participate  
36 in treatment and asking the Parole Board to include in its  
37 deliberations whether somebody has completed treatment or  
38 not.  
39

40 THE CHAIR: What about the person, again, who can't by  
41 reason of their circumstances, there's nothing they could  
42 do about it, is it relevant to the Parole Board's decision  
43 then?  
44

45 MR VERDOUW: That is not a question I can answer; they are  
46 an independent body. It is a good question but it's not  
47 one that I can answer.

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THE CHAIR: You don't know the answer.

MR VERDOUW: No.

THE CHAIR: The reasons of the Parole Board don't tell you how they're operating?

MR VERDOUW: They do sometimes come up with reasons and I don't actually follow them closely, I do apologise for that.

THE CHAIR: All right. We're going smaller, I suppose: the ACT.

MS BROWN: Good morning. I am Angela Brown from ACT Corrective Services. Yes, I acknowledge the difficulties; it's a small jurisdiction. We offer one treatment program both in the community and in the prison. It is the same program which is a rolling program called the Adult Sex Offender Program, ASOP. We also offer individual programs, again in the prison and in the community, for those with intellectual disability or those who are categorically denying their offences.

To be eligible for the program you need to be male, convicted, and sentenced. Similar to Tasmania, we don't commence treatment until the sentence has commenced. Because of the nature of our jurisdiction and the programs, you can commence treatment within the prison and then complete it, when you're released, in the Community Corrections Office, which has some advantages.

We also offer a maintenance program for those who complete the main treatment program. The treatment program has just actually been reviewed last year. It did take up to two years to complete. We now offer it twice a week, so it takes approximately 12 months to complete and then, depending on the length of sentence they still have in the community, they remain in the maintenance program on a monthly basis after that.

In terms of the Categorical Deniers Program, that's offered by a consultant, a senior psychologist. It is actually starting this month, so it is very new, so we have no real data to offer there. We do have a range of offenders within the programs in the prison and the

1 community who might have some level of denial, but we do  
2 work with them. There is some pre-treatment readiness that  
3 happens before the programs start in the prison and  
4 community. It is motivation interviewing, it's CBT based,  
5 it is not at all treatment or sex offender focused, it is  
6 very much preparation for group readiness.

7  
8 I do have numbers for you but they are very small  
9 compared to the rest of the jurisdictions, as you can  
10 imagine. Currently, we have within the prison in the  
11 treatment program 13 participants and currently in the  
12 community we have seven. For the year 2014-15 in the  
13 community we had a total of 19 participants, 11 successful  
14 completions, seven still in treatment and one offender was  
15 deported. It is a very good completion rate but very small  
16 numbers. In the AMC we have seven completions for the  
17 2014-15 financial year.

18  
19 THE CHAIR: Northern Territory?

20  
21 MS NOBBS-CARCURO: Amanda Nobbs-Carcuro. I am the  
22 Executive Director of Correctional Services and Programs.  
23 In the Northern Territory, similarly, we also have  
24 preparatory programs. We have something called "Safe Sober  
25 Strong". We have two specific sex offender programs, one  
26 known as the Responsibility Safety Victims Plans Program  
27 and that's for low to moderate risk offenders and then the  
28 Sex Offender Treatment Program. We also have a maintenance  
29 program and that's for inmates whose release date is beyond  
30 their treatment.

31  
32 As I said, the eligibility to the RSVP is for male  
33 inmates who have a sexually related offence assessed as low  
34 to moderate. The SOTP is moderate to high. We don't  
35 separate moderate and high.

36  
37 In terms of tailored programs, we have the RSV program  
38 for those inmates with literacy and numeracy difficulties.  
39 It specifically incorporates various types of learning  
40 styles. It is designed for indigenous males but it also  
41 accommodates non-indigenous males and it relies on learning  
42 styles around art, yarning and storytelling in the program.  
43 In terms of numbers, again, it's a small jurisdiction.

44  
45 For the SOTP, the moderate to high, there were nine  
46 enrolments, one withdrew, eight continuing; for the RSVP,  
47 nine enrolments, nine completions. We also do individual

1 treatment for those who can't participate in the group.  
2 Sessions are voluntary and they are closed groups.

3  
4 THE CHAIR: You have a particular way of framing the  
5 program for indigenous people; is that right?

6  
7 MS NOBBS-CARCURO: Yes.

8  
9 THE CHAIR: What about the other States? Does anyone else  
10 have, as it were, an indigenous component in their program?

11  
12 MR PHELAN: We have an Aboriginal and Torres Strait Island  
13 specific program that we run out at Lotus Glen Correctional  
14 Centre. We work quite closely with Northern Territory  
15 and Western Australia --

16  
17 THE CHAIR: Are you doing the same thing, effectively?

18  
19 MR PHELAN: It is very similar around the yarning and very  
20 narrative in nature. It is the same core human construct  
21 but it's pitched at a culturally appropriate level where  
22 the offenders are their own cultural experts because  
23 they're so diverse and we work very closely with  
24 Northern Territory and Western Australia to make sure that  
25 we're up on the literature and the best practice or  
26 informed practice for that cohort.

27  
28 THE CHAIR: What about the other States? New South Wales?  
29 Victoria?

30  
31 MS DONALDSON: We don't run specific programs for  
32 Aboriginal and Torres Strait Islander offenders. However,  
33 we use the support of a regional Aboriginal projects  
34 officer. Similarly, we work with the individual's needs  
35 and responsivity issues and their own learning styles  
36 within that group environment. When it comes to presenting  
37 work, such as a life story or a life history, we often  
38 invite a RAPO, a Regional Aboriginal Projects Officer, into  
39 the programs to support the offender and to support staff  
40 working with the Aboriginal and Torres Strait Islander  
41 offenders.

42  
43 THE CHAIR: Victoria?

44  
45 MS BRADEN: Similarly, we don't have a discrete program  
46 but we do consider the level of cultural immersion in  
47 relation to indigenous offenders and we will target and

1 access support through our Aboriginal support workers,  
2 liaison officers, within the correctional system to support  
3 that. We have a much more urbanised indigenous population  
4 compared to remote areas in Queensland.

5

6 THE CHAIR: South Australia?

7

8 DR PHARO: We don't offer a separate program. The way we  
9 approach it is we have Aboriginal support officers at each  
10 of the institutions who provide support. We also have a  
11 Central Aboriginal Services Unit and we seek specialist  
12 supervision from them in relation to any Aboriginal  
13 offenders that we have placed in the programs. We do some  
14 additional work on the side supplementary to the main  
15 program with those offenders.

16

17 THE CHAIR: You would have Aboriginal offenders from  
18 remote locations, I assume, in South Australia.

19

20 DR PHARO: Yes, we do.

21

22 THE CHAIR: Have you talked to Queensland and the  
23 Northern Territory about what they're doing?

24

25 DR PHARO: I think similar to my comment on the moderate  
26 intensity programs, it is something that we are very  
27 interested in pursuing.

28

29 MS SWAN: We do have preparatory programs which are  
30 Aboriginal specific, so pre-criminogenic programs. We then  
31 have a preparatory program that some of our Aboriginal  
32 offenders go into who then have a pathway into, say, our  
33 sexual behaviour programs, but we are aware that it is  
34 something that we would like to do, as Henry says.

35

36 THE CHAIR: I should know the answer to this but I confess  
37 I don't, but in terms of the effort that has been placed  
38 into assisting sexual offenders who become part of the  
39 prison system, are we investing similar levels of effort in  
40 relation to prisoners generally, or are sexual offenders  
41 given more effort per, as it were, offender than general  
42 offenders? Can anyone tell me?

43

44 MS BROWN: There is an emphasis in our jurisdiction for  
45 offering all prisoners access to treatment, so we do have a  
46 quite large compendium of programs. That is definitely  
47 a --

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THE CHAIR: So you would say that there's no particular extra effort for sexual offenders, or is there?

MS BROWN: There's no extra emphasis, no.

MS SWAN: Henry may add to this. I think in South Australia, certainly sexual offenders and to some extent violent offenders, because of the impact that their offending has on victims, the profound impact, we probably do put extra effort into those offenders and that although we have broad general offenders programs, the length and duration and intensity of the programs for high and moderate risk sexual offenders that we put in is probably our most focused effort.

THE CHAIR: What about the other three larger --

MS DONALDSON: At this point, I would also like to introduce Jayson Ware, who is our Executive Director for Offender Services and Programs. Actually, Corrective Services offers a suite of programs for offenders at moderate risk for other more general offences. I think Jason might be best to speak to the group's suite.

MR WARE: I do have two hats on today. University of New South Wales --

THE CHAIR: I was going to say your label might be slightly misleading.

MR WARE: Yes, I try my best. In answer to the question, we have three types of offenders which we put intensive treatment resources into. Sexual offenders is one, violent offenders is another, and then we have a similarly intense treatment program for alcohol and drug dependent offenders. In actual fact that's the large majority of many of our offenders that undergo the intensive treatment.

THE CHAIR: Victoria?

MS BRADEN: Similar to South Australia and New South Wales, but I think in respect of sexual offending we do provide a higher level of service in relation to the spectrum of sexual offenders processed through the system. We have the post-sentence scheme as well, so there are extra elements that are aligned with that. At the same

1 time we have a government that is very committed to family  
2 violence, general violence, drug and alcohol, a suite of  
3 programs that are arranged. I think that the sexual  
4 offender pathway is a more extended one at present compared  
5 to the other cohorts.

6  
7 THE CHAIR: And Queensland?

8  
9 MR PHELAN: We are very similar to Victoria and New South  
10 Wales. I don't know that we'd say we've placed equal  
11 weighting in the context of the harm associated with the  
12 cohort which you are actually treating. We have  
13 high-intensity violence, we have high-intensity substance  
14 abuse which is high correlated to ongoing offending.

15  
16 Again, we have the pressures of post-sanction  
17 sentencing as well, so there is a lot of due diligence that  
18 has to be followed to make sure that these programs are  
19 afforded to all sexual offenders who have committed a  
20 sexual offence. It is more in relation that it is also a  
21 very complex treatment area and they range from 75 hours up  
22 to 350, and it is an ongoing treatment area versus some of  
23 the other areas in which they can actually be  
24 self-perpetuating: following substance abuse,  
25 for instance.

26  
27 It is a far more complex area. At face value,  
28 numbers wise we treat more substance abuse than we do  
29 sexual, but the amount of investment to actually get the  
30 same treatment impact, it looks as though we are investing  
31 a lot more time in sexual offending. It is a far more  
32 complex treatment area.

33  
34 THE CHAIR: Just before we break for a cup of tea can  
35 I expand our thinking. Really, this is preparatory to what  
36 is going to happen after morning tea and looking also at  
37 all of the people we have here who have expertise outside  
38 of the system - looking in, as it were - all of you in this  
39 room, I am sure you understand, know more about what you're  
40 talking about than we do, that's the first thing, and we're  
41 totally dependent upon what you're telling us in relation  
42 to how you do it.

43  
44 The impression I have is that you're all very keen to  
45 learn both across jurisdictions and I assume  
46 internationally as well and I assume there's a whole lot of  
47 international learning. Can anyone in a couple of minutes



1 just tell us are there significant differences in what we  
2 are seeking to do in Australia and with what is being done  
3 in other significant jurisdictions in other parts of the  
4 world, or are those jurisdictions which are attempting to  
5 address the issue working pretty much down the same path?  
6 Can someone tell us?  
7

8 DR WONG: I am associated with Swinburne but I did most of  
9 my work, actually, in Canada within the  
10 Corrections Services of Canada and then later on in the UK  
11 and I also did quite a lot of work consulting in different  
12 states in Australia. From what I've heard, I think the  
13 programs are pretty much in line with the international  
14 best practice approaches to risk-need-responsivity  
15 principles and it is very important, it is well recognised,  
16 it's an important guideline, whether it's a sex offender  
17 program or non-sexual violent offender program.  
18

19 I am very pleased to hear that there is a lot of  
20 effort being put into trying to engage deniers, because  
21 quite often deniers are the ones who tend to be high risk  
22 and if you don't get them into treatment programs then the  
23 people with the high risk don't get the treatment they  
24 need.  
25

26 In terms of follow-up community support, it is also  
27 very important and it is generally recognised as almost a  
28 must to continue with the continuity of treatment, so  
29 I also hear quite a lot about that.  
30

31 What I haven't heard much of is in terms of how the  
32 assessments are done in the front end of it and also how  
33 the treatment, progress and change are monitored and  
34 reported, because also that would be very important for  
35 Parole Board decision making as to what extent a person has  
36 improved and whether the improvements are in some way a  
37 reflection of reduction in risk in the community. The  
38 other bit is also in terms of evaluation which is also  
39 useful for feedback into the service as to how well the  
40 programs are doing and so on. Yes.  
41

42 THE CHAIR: We are going to break for a cup of tea, but  
43 the context for the discussion we will have after morning  
44 tea is in part of course born from a community expectation  
45 which will be like going to the doctor, if you get treated  
46 you can be fixed, but as all of you understand, it is more  
47 complex than that, but we will be seeking to say what we

1 can as a Royal Commission about what all of you have to  
2 tell us about how close it is to the outcome if you go to  
3 your doctor with the flu and whether or not we need to  
4 understand, and everyone needs to understand, that this  
5 problem has a somewhat different context.  
6

7 If you like, we have titled it "Evidence of  
8 Effectiveness". We are looking to see just what we can say  
9 all of you have told us about how effective the processes  
10 are. We will break now for a cup of tea, which is in the  
11 room down the corridor I think. Leigh's people can help  
12 show you the way. Thanks.  
13

14 SHORT ADJOURNMENT  
15

16 THE CHAIR: We have with us, but she is tucked in the  
17 corner, Jessica Pratley. I understand, Jessica, you  
18 operate in this field but, should I say, in the private  
19 sector; is that right?  
20

21 MS PRATLEY: Yes, that's right.  
22

23 THE CHAIR: Do you know everyone here or do they know you?  
24

25 MS PRATLEY: Yes, I have met most people.  
26

27 THE CHAIR: Can you tell us what you do?  
28

29 MS PRATLEY: I am a forensic psychologist with Lennings  
30 Seidler Collins Psychology. We provide assessment and  
31 treatment of a range of offenders, but part of our core  
32 business is around sexual offenders.  
33

34 In terms of treatment, we offer a group treatment  
35 program and we offer individual treatment as well.  
36

37 Our group treatment program has been running for six  
38 years now. It is a rolling program and I guess in terms of  
39 the components it is very similar to the programs that  
40 other people have spoken about so far.  
41

42 Our referrals primarily come from solicitors. We  
43 receive self-referrals from people, we receive some  
44 referrals from Corrective Services and we also receive  
45 referrals from Family and Community Services.  
46

47 Some of our participants are going through a criminal

1 justice process; some have already been sentenced; some  
2 have been released from custody; and some have been going  
3 through a Family and Community Services process, so they  
4 haven't actually faced any charges and aren't going to face  
5 any charges, for whatever reason, but are still deemed to  
6 be needing treatment for sexually abusive behaviour.  
7

8 The program takes 12 to 18 months to complete,  
9 depending upon a person's level of need. We don't rely on  
10 risk assessments or levels of risk for people coming in to  
11 the program, although, primarily, our participants are of  
12 low or moderate risk. We have had a few high-risk  
13 offenders, but it is quite challenging to manage those  
14 clients within a private practice model.  
15

16 The program runs on Friday morning from 9 until 12, so  
17 it is quite a big commitment and a big investment from  
18 people to participate in that for that 12-to-18-month  
19 period.  
20

21 THE CHAIR: And cost?  
22

23 MS PRATLEY: And, of course, it costs. It is \$100 per  
24 session which program participants have to fund themselves.  
25

26 THE CHAIR: With no refund or support from any other  
27 source for that cost?  
28

29 MS PRATLEY: No, no. We will negotiate with people who  
30 genuinely cannot afford the program. If we believe that  
31 they really do need treatment then we are happy to  
32 negotiate. It does mean that a lot of the time the program  
33 operates at a loss, and when it is profitable it is very  
34 minimally profitable.  
35

36 So my understanding is that a lot of our referrals  
37 come - not a lot, but some of our referrals come - from  
38 people who didn't receive access to treatment in custody  
39 and, for whatever reason, can't access the Forensic  
40 Psychology Services program. So we do liaise a fair bit  
41 with Community Corrections around individual treatment  
42 clients.  
43

44 THE CHAIR: Are there people like you operating across  
45 Australia in this space?  
46

47 MS PRATLEY: I believe so, yes. In New South Wales I know

1 of one other group program that is offered, that's offered  
2 by the Pastoral Counselling Institute. But, again, that is  
3 Sydney based. I don't know of any group programs that are  
4 offered in regional or rural New South Wales.

5  
6 THE CHAIR: Just a curio that we have: does anyone offer  
7 a program to women offenders?

8  
9 MS BRADEN: We don't, and I think I can perhaps speak for  
10 most of the jurisdictions. The cohort of female sexual  
11 offenders is very small across each of the States, and  
12 their pathway to offending is quite different in comparison  
13 to the male pathways of offending. The base rate of  
14 recidivism for females is extremely low - I think it's  
15 around 0.1 per cent. So our approach to working with  
16 female sexual offenders generally across the jurisdictions  
17 is more of an assessment process, but mainly a general  
18 offending pathway, but we may also do some offence-specific  
19 work on an individual basis.

20  
21 THE CHAIR: Yes. I want to turn now to the complexities  
22 of the outcomes, if you like.

23  
24 I should disclose - all of you would know - that  
25 judges, at least in some States, are required to look at  
26 this issue in terms of continuing detention. But you are  
27 there dealing with high-risk offenders, by definition.  
28 I have sat through a number of debates, with some people  
29 saying it is very good, other people saying it is hopeless,  
30 and you would all know of those potentially extreme views  
31 about the programs that are offered and their outcomes.

32  
33 Judges, for better or for worse in that context, have  
34 to make decisions about whether or not people should be  
35 released and, if so, under what circumstances.

36  
37 It is a very difficult task for a judge, I can assure  
38 you. When someone has come to the end of their sentence,  
39 to be saying to them "No, you have to stay in continuing  
40 incarceration" is a very hard decision to make.

41  
42 To start off the discussion as to outcomes, if you  
43 like, I thought maybe, Stephen, you might like to offer us  
44 your views.

45  
46 PROF SMALLBONE: Thank you, judge, yes. I am a professor  
47 at the Griffith Criminology Institute at Griffith

1 University in Brisbane.

2  
3 My view on the evidence for effectiveness is that it  
4 remains equivocal. The outcome studies I think indicate  
5 that there is wide variation in outcomes across programs,  
6 so while many of the more recent meta-analytical reviews  
7 are concluding that overall there is a positive effect, if  
8 you look at the variations across the programs that are  
9 included in those studies we find programs that work very  
10 well, programs that have a neutral effect and programs that  
11 make things worse.

12  
13 So the real challenge, I think, in this area is to be  
14 finding out what it is that are the effective elements of  
15 the better programs, which are the better kinds of programs  
16 and which are the effective elements within those programs.

17  
18 I think that the designs of evaluation studies are  
19 problematic. It is very difficult to use a randomised  
20 control design. This is a design that is often regaled as  
21 the gold standard evaluation design for effectiveness, it's  
22 very commonly used in medical contexts. But we're not  
23 dealing here with a medical problem.

24  
25 You yourself, judge, used the analogy of the flu.  
26 Well, most people with the flu probably will have the same  
27 bacterium or virus or whatever it is that is causing that  
28 disease, and the response to it is to counter that very  
29 specific cause. But we are dealing here with a very  
30 complex set of causes and they are not all the same for  
31 each individual.

32  
33 So one of the facts, I guess, as I see it in this  
34 field is that the population of people who are convicted of  
35 sexual offences is extraordinarily heterogeneous. There  
36 are remarkable variations across that population.

37  
38 I think one of the challenges for Corrections, in  
39 particular, is to find out how to provide - well, we see  
40 from the description of the programs here, and they  
41 certainly look like they have improved since I was first  
42 involved with this 25 years ago, but still we are in a very  
43 structured program model, a group-based model, that is  
44 trying to engage with a population of people whose  
45 individual circumstances and the reasons for their  
46 offending vary enormously.

1 Vanessa Swan mentioned the importance of  
2 individualising, I think - or somebody talked about  
3 individualising the process; in fact, it was New South  
4 Wales - within a group-based structured program, and that  
5 makes a lot of sense, I think, but there are limits,  
6 I think, to what can be done.  
7

8 One of the things that I think is unclear about the  
9 outcomes comes from the way that the evaluation studies are  
10 designed. There are very, very few randomised trials, as  
11 I say, so the alternatives are often some kind of  
12 comparison between a treatment group and a non-treatment  
13 group. A very common design is, I think unfortunately,  
14 comparisons between those who complete treatment and those  
15 who dropped out of treatment.  
16

17 Another problem, I think, with this is that the risk  
18 principle in offender rehabilitation tells us that the  
19 biggest bang for your buck, if you like, for resources, is  
20 to try to engage with the highest risk offenders, and  
21 I have heard descriptions of high-risk programs here, but  
22 my experience actually is that the highest risk offenders  
23 don't often go into these programs because they are too  
24 difficult. These are often the people that end up,  
25 I presume, in your courts and your fellow judges' courts,  
26 where they have failed to engage in programs --  
27

28 THE CHAIR: Not necessarily, but that can be the case.  
29

30 PROF SMALLBONE: Well, nevertheless, my experience is that  
31 programs in Corrections often are designed for kind of  
32 a mainstream or, you know, more or less average case, if  
33 you like, and where there are individuals who don't fit  
34 easily into those models there are great difficulties with  
35 engagement in these services, and they will often not have  
36 anything, or people will really struggle.  
37

38 This is a professional issue, I think - a professional  
39 development issue, perhaps, because I think that it  
40 requires a great deal of skill and expertise to be able to  
41 engage effectively with the most dangerous and most risky  
42 people. And from a community safety point of view, they  
43 are exactly the people that most need the attention.  
44

45 So there are questions - the base rates of  
46 re-offending are still quite low amongst sex offenders,  
47 which means that most of the people who come into these

1 programs probably wouldn't offend even if they didn't come  
2 in to the program. So there is a lot of effort going in to  
3 try to cover the kind of higher-risk people, but that will  
4 include a lot of - well, frankly, a kind of wasted effort.  
5 I'm not wanting be to be critical of the efforts of the  
6 people around the table. I am impressed with what is going  
7 on and I admire the kind of commitment to this, it is an  
8 important area. But, nevertheless, from a critical point  
9 of view I think these are the kinds of hard questions that  
10 we really need to wrestle with.

11

12 THE CHAIR: Can I try to reduce it to an example: if you  
13 had a man who had offended and you were considering them  
14 for release under parole, and they were a serious offender,  
15 but their time for eligibility for parole was up, and they  
16 had gone through a treatment program, would you say that  
17 the fact that they had successfully completed the program  
18 was relevant to the decision as to whether or not it was  
19 appropriate to release them into the community?

20

21 PROF SMALLBONE: I would say that that would have limited  
22 relevance. There is certainly a principle in psychiatry,  
23 in forensic psychiatry - not so much in forensic  
24 psychology - that a person, a practitioner, who is involved  
25 in the treatment of a patient, in psychiatry terms,  
26 shouldn't be the person who makes the assessment of that  
27 person, because the person who is involved in treatment has  
28 hopes for the success that reflect on their own  
29 professionalism.

30

31 So I would say that what is really needed for parole  
32 boards is an independent assessment of that person, and  
33 I wouldn't personally give too much weight to the  
34 conclusion of a treatment provider about how that person  
35 has done.

36

37 THE CHAIR: But the mere fact that they have gone through  
38 treatment, apparently successfully, when being looked at by  
39 the independent person - would that be a relevant factor  
40 for them to have regard to when advising the parole board  
41 whether they should be released?

42

43 PROF SMALLBONE: Yes. Necessary but not sufficient, if  
44 you like.

45

46 THE CHAIR: Yes. So to try to capture the essence of what  
47 you are saying, you have reservations but accept that these

1 programs can make a positive contribution to someone's  
2 future behaviour.

3  
4 PROF SMALLBONE: Absolutely.

5  
6 THE CHAIR: Is that where it sits?

7  
8 PROF SMALLBONE: Absolutely. But could I say one more  
9 thing. I think the comment was made that the programs in  
10 Australia are pretty much in line with international best  
11 practice standards, and I agree with that, but I think  
12 there is a big problem across the board, that this is an  
13 area where the idea of treatment has become heavily focused  
14 on therapeutic interventions.

15  
16 Treatment of offenders really may involve  
17 a therapeutic component, but it also involves  
18 a risk-management component. The aim of all of this is to  
19 prevent these people from committing further offences. So  
20 treatment is never, in my mind, an end in itself. It is  
21 one way of contributing to that outcome.

22  
23 But I think the problem can be that this whole area  
24 becomes kind of bogged down in this idea that it is all  
25 about therapy, and that is based on the idea - what I think  
26 is an erroneous idea - that the whole problem exists within  
27 that person.

28  
29 You know, it is so easy to give an example, let's say,  
30 of an Aboriginal offender from a remote community who is in  
31 prison, who gets therapy. So the idea is that somehow the  
32 therapy will have an effect that will inoculate that person  
33 against the extraordinarily powerful criminogenic effects  
34 of their environment once they return. And I think, you  
35 know, there has been talk here, which is excellent, that  
36 there is a focus on - and, sorry, this is your point,  
37 Vanessa - linking with Community Corrections. Absolutely  
38 critical. We know that community programs actually work  
39 better than custody-based programs, but most of the  
40 resources are going into prisons. But it is that return to  
41 those places. It doesn't make any sense to me at all that  
42 anyone would expect, under those circumstances, that  
43 treatment would have any useful effect at all.

44  
45 And so there needs to be, I think, some attention to  
46 what is going on where that person is being returned, and  
47 that requires somebody to go there and to be there and to



1 look at it and understand it. So there are elements of  
2 this to do with the risk management aspect that I really  
3 think need a lot more attention than the more conventional  
4 therapeutic aspect.

5

6 THE CHAIR: Jayson, I think you have been involved in some  
7 reviews or evaluations of CUBIT; is that right?

8

9 MR WARE: Yes, in part.

10

11 THE CHAIR: What is your view about the effectiveness of  
12 the programs that are available?

13

14 MR WARE: Firstly, I actually agree wholeheartedly with  
15 Stephen. If we think of every single individual sex  
16 offender as being very different, just like we all are  
17 around the table, then the actual requirements of the work  
18 that we have to do with them, both within a treatment  
19 context within custody and then upon release are  
20 extraordinarily vast. So it is very difficult to actually  
21 think that a treatment program, by itself, could actually  
22 show some effect.

23

24 That's one of the other difficulties, too, that people  
25 don't just do the treatment program: they have Community  
26 Corrections supervision; they might have additional work  
27 with a psychiatrist/psychologist, around mental health  
28 issues. So evaluating a program without any regard to all  
29 of those issues then becomes very difficult, to make sense  
30 of what that evaluation actually tells you. Therefore, one  
31 would require very large numbers of people within the  
32 sample to try to control for all those other factors which  
33 I think would be very improbable to do.

34

35 So, therefore, as Stephen was saying, most of our  
36 evaluations are based on methodologies that are less than  
37 sound, but, nonetheless, are the best we can do within our  
38 resources and within our constraints.

39

40 For example, in New South Wales, we actually treat,  
41 prior to release, the majority of sex offenders, so we  
42 don't actually even have an adequate control group, if we  
43 were to assume that having an untreated control group was  
44 an adequate methodology.

45

46 So we currently have an independent researcher  
47 thinking through complex economic models of how to actually

1 analyse our program, and these are more complicated than  
2 I would like to actually think through, because I couldn't  
3 understand, in the first glance, how they would actually do  
4 these things.

5

6 THE CHAIR: Can I put, then, in that context, a pretty  
7 harsh question to you: if I was the minister and I had  
8 been told I had to cut my budget, would I even contemplate  
9 cutting back or eliminating programs in the prison system  
10 to treat sexual offenders?

11

12 MR WARE: That's a question the minister has put to me  
13 personally on a number of occasions, actually, and I think  
14 I have actually, in your courts previously, your Honour,  
15 explained some of those perspectives.

16

17 THE CHAIR: To me?

18

19 MR WARE: Yes, I think so. I remember it very well, that  
20 court experience. But certainly our ministers are very  
21 risk averse and very careful with respect to sex offending  
22 matters and, therefore, are likely to actually throw  
23 resources into sex offender treatment, even in the absence  
24 of empirical evidence.

25

26 THE CHAIR: Maybe, but maybe I'm a different minister and  
27 I say, "Okay, you tell me: why should I go on spending  
28 this sum of money on this program?"

29

30 MR WARE: We tend to say there are two issues. One is  
31 community confidence and the other is actually the impact  
32 of our interventions and risk management approaches.

33

34 So, clearly, our risk-averse minister, even the second  
35 one, would be interested in community confidence and would  
36 want to show the community that we are actually making an  
37 effort. Whether that effort is actually an  
38 over-utilisation of resource is a question for us to  
39 consider, but if we put that to the minister, the minister  
40 would say to us, "Well, what is the most effective way of  
41 doing this?", and our response would be, as Stephen was  
42 saying, we need to wrap around all of our services, not  
43 just within Corrections but in the private sector, the NGO  
44 sector. We need to have a really considered approach to  
45 actually assisting these individuals post their sentence,  
46 and that's very difficult. We have problems finding  
47 housing. If we don't find adequate housing for some of

1 these individuals, assuming they don't have a family to go  
2 back to, and if they are in remote areas, we have the  
3 sub-context of the remote area to deal with.  
4

5 And the opposite side of that, actually, is that with  
6 the remote offenders, certainly in New South Wales, the  
7 first challenge is actually getting them to come from the  
8 prison that they are housed in - for example, way out  
9 west - to Sydney, away from their family, to do a treatment  
10 program. In actual fact, we would advise the minister, we  
11 should take our efforts to them in that correctional centre  
12 so that their family remains close but, again, it is  
13 something difficult for us to do.  
14

15 THE CHAIR: Because of cost?

16 MR WARE: Cost.

17  
18  
19 THE CHAIR: So I'm the minister, so I say, "Keep going",  
20 do I?

21  
22 MR WARE: Most usually. I go back to the minister saying,  
23 "I would like to have some additional resources, minister."  
24

25 THE CHAIR: I expected that. Vanessa?

26  
27 MS SWAN: Can I also attempt to respond to that question.  
28 I think because of the profound harm that sexual offending  
29 has to victims, a small amount of benefit in terms of  
30 reducing recidivism is very profound in the experience of  
31 individual victims, so I would argue that to the minister.  
32

33 I would also say that, a bit like if we take the  
34 medical model analogy, with some cancers we're not sure,  
35 really, that what we do is particularly effective at this  
36 point in time, but we don't say to those patients, you  
37 know, "We're not going to spend that health dollar; we will  
38 just put it over here instead" - it is the same kind of  
39 moral social conundrum.  
40

41 And the other bit is if we do treat that cancer, say,  
42 and we continue to research the effectiveness and what is  
43 the most effective constellation - and we are hearing  
44 evidence that, yes, there are some things in treatment, and  
45 the meta-analyses are problematic because they keep on  
46 counting apples and oranges together and then they get  
47 a kind of fruit salad that doesn't really tell us very

1 much - what we need to do is do better research, work out -  
2 which I think we are progressing down that path - what  
3 combination of community support, treatment programs,  
4 custodial environment, treatment environment, community  
5 attitudes, conditions that produce sexual offending in the  
6 first place - that whole kind of range of what we can do,  
7 we need to get better at working out what are the elements  
8 that stop this. So unless we keep going, we won't get  
9 better at knowing that.

10  
11 THE CHAIR: Jane, what is your perspective on all of this?  
12

13 PROF GOODMAN-DELAHUNTY: Thank you, judge. So I'm from  
14 Charles Sturt University and I'm not a treatment provider.  
15 I have been involved only in the sense of doing some  
16 evaluation of, in particular, one community-based program  
17 here in New South Wales.  
18

19 But I think there are a number of themes that other  
20 people have already mentioned that perhaps I would like to  
21 reiterate a bit, and the first one that I have a bit of  
22 concern about is that although I think it is excellent that  
23 there is reliance on a lot of formal risk instruments that  
24 have played such a central role, not only in how people are  
25 assigned to different programs but also post-sentence  
26 release, I think one of the difficulties with child sex  
27 offending is a lot of the risk instruments aren't very  
28 sensitive to the kinds of criminogenic needs and risks that  
29 are really there.  
30

31 So certain issues that we see with institutional  
32 offenders or intrafamilial child sex offenders that are  
33 standard protective factors - such as that they are  
34 employed, that they are often married, and so on - tend to  
35 depress the scoring of their risk on these instruments.  
36 And so by the time they are assessed, they are not even  
37 going to be eligible for these programs.  
38

39 The groups that I evaluated all scored so low they  
40 would never have been admitted into a program, and if they  
41 were incarcerated, they received fairly low sentences from  
42 our control group compared to those who were eligible for  
43 community-based treatment.  
44

45 So it does seem as if there is perhaps a group of  
46 people who are posing quite a strong risk, in fact, to  
47 children in particular, who are sort of flying under the

1 radar in a way, compared to others, and they might be  
2 scoring quite differently if the instruments were more  
3 sensitive.  
4

5 This really goes back to, I think, a point that  
6 Stephen and others have made about the need to take into  
7 account that it is a very heterogeneous group of offenders.  
8 It is not a one-size-fits-all kind of approach, and I think  
9 we really have heard people acknowledge the necessity to  
10 use some more individualised approaches. So I think that's  
11 a bit of a difficulty.  
12

13 The other issue that I think has emerged out of some  
14 recent research is that people who are sex offenders, and  
15 child sex offenders included, don't only engage in sex  
16 offending in terms of their criminal activities, and yet  
17 the programs that are offered tend to target almost  
18 exclusively sexual offending but, in fact, what we were  
19 surprised by was the high proportion of other kinds of  
20 crimes in their criminal histories and backgrounds, and it  
21 indicates that perhaps some of the intervention should be  
22 broader.  
23

24 Obviously, you want to reduce the risk of sex  
25 offending - I'm not saying that should be diminished - but  
26 perhaps the aim of some of the treatment is mis-allocated,  
27 and that goes to some of the discussion we have had here  
28 earlier today but how general that should be in order to  
29 really target the criminogenic needs that are there.  
30

31 I think those are some of the critical comments that  
32 I have just about what is being offered, perhaps, in  
33 custodial programs.  
34

35 But, by and large, I think I emerged, as an objective  
36 evaluator, as a great supporter of what can be done in a  
37 community-based program with people who might be higher  
38 risk than everyone would assume, with a fairly intensive  
39 treatment that was regarded as quite stringent by the  
40 participants and had a phenomenal success rate, so that  
41 where we did have careful controls we were able to show  
42 that, for example, those who went through standard  
43 sentencing and prosecution re-offended 4.6 times or more  
44 faster, and the likelihood of offending, compared to those  
45 who went through the community-based program. So there  
46 were quite strong effects of the community treatment when  
47 it was well focused for those targeted offenders.

1  
2 I thought that was very encouraging news, to realise  
3 that, in fact, the resources that might be allocated and  
4 that are so expensive in custody could perhaps be diverted  
5 more powerfully to producing good results through some of  
6 the community-based programs that most of the corrections  
7 services now are engaging in. I think it is a very vital  
8 area to work on, and particularly because that is forcing  
9 the offenders to deal with the opportunities to re-offend  
10 in a way that success in treatment in custody does not  
11 allow them to be tested in that way.

12  
13 THE CHAIR: If you like, it is a real-life challenge?

14  
15 PROF GOODMAN-DELAHUNTY: Yes.

16  
17 THE CHAIR: What does New South Wales think - Meagan, what  
18 do you think about that?

19  
20 MS DONALDSON: I think it's a unique - well, not unique,  
21 but my understanding of Cedar Cottage was it was quite  
22 a specific offence group, in that they were lower -  
23 I wasn't sure about the treatment intensity, were they  
24 a lower-risk group?

25  
26 PROF GOODMAN-DELAHUNTY: I think Jess Pratley is really  
27 the best-equipped person to address that question.

28  
29 MS PRATLEY: Yes. I can speak to this because I was  
30 previously employed as the senior clinician at the New  
31 South Wales Pre-Trial Diversion of Offenders Program, Cedar  
32 Cottage. So program participants attended on a weekly  
33 basis. It alternated between individual sessions and group  
34 therapy sessions. That was for a period of a minimum of  
35 two years and a maximum of three years.

36  
37 I guess the other feature of the program was the  
38 family involvement, and we talk about that community  
39 involvement being really important. I guess this is  
40 a point that I wanted to make, just around when we are  
41 looking at effectiveness of a treatment program, recidivism  
42 is quite a blunt measure, and particularly when we are  
43 thinking about institutional abuse or intrafamilial abuse  
44 where there is a relationship that has been present in many  
45 cases, where victims are not only dealing with the impact  
46 of the sexual abuse, but also dealing with that betrayal,  
47 with that loss of connection. It could be a whole range of

1 issues there.

2  
3 But for some of those, the children and young people,  
4 we need to be looking at how the treatment of an offender  
5 can actually support them, so thinking about those  
6 restorative justice models which very much form the  
7 foundation of the Cedar Cottage program.

8  
9 MS DONALDSON: I think it actually highlights the need, or  
10 coming back to what Professor Smallbone was saying, that we  
11 need to have a look at what is working for whom. Certainly  
12 research is not my area of strength - I am a clinician;  
13 I do my best work in a group room - but I think that's what  
14 we are starting to look at, is what works best for whom,  
15 and considering the victim perspective is really important  
16 for any treatment program.

17  
18 I think one of the issues that I would like to touch  
19 on, though, is I think one of the strengths that we have in  
20 identifying an individual treatment plan at the beginning  
21 of treatment is that we are able to address the more  
22 general recidivism rates or risk of recidivism for these  
23 offenders. So certainly within our program, when we are  
24 looking at their risk assessments and areas for risk, we  
25 address those, you know, substance use, domestic violence,  
26 if that's an issue, violence - we incorporate all of their  
27 treatment needs in the one program, because it is  
28 a high-intensity program, so that an offender is not  
29 required to participate in a high-intensity sex offender  
30 program and a violent offender program and a substance  
31 abuse program.

32  
33 We have a more holistic approach to what are this  
34 offender's needs to prevent him committing a sexual or any  
35 other offence.

36  
37 THE CHAIR: How long did Cedar Cottage run for?

38  
39 PROF GOODMAN-DELAHUNTY: At least 25 years; I think it  
40 started in the late 1980s.

41  
42 THE CHAIR: Why did it stop?

43  
44 PROF GOODMAN-DELAHUNTY: There was concern in the  
45 community that child sex offenders needed to spend time in  
46 prison based on the harm to the victims. It was really a  
47 sort of a punitive response that really didn't take into

1 account --

2

3 THE CHAIR: They needed to be punished, in other words,  
4 yes. That was expressed ultimately through a ministerial  
5 decision; is that what happened?

6

7 PROF GOODMAN-DELAHUNTY: As I understand it, yes.

8

9 THE CHAIR: I get the impression both of you would be  
10 saying maybe that's not the right way to go.

11

12 PROF GOODMAN-DELAHUNTY: I think what happened was a burn  
13 was put on the Department of Corrective Services to extend  
14 a community program to fill the gap and I think that  
15 probably has also led to the greater expansion of private  
16 services offering something similar. In other words, there  
17 is a need, and if you think about the trajectory, we ought  
18 to be thinking about prevention as well. Where do  
19 individuals go if they realise that they're sexually  
20 attracted to children or might be thinking about offending  
21 but haven't yet got to that point? If there aren't  
22 community based treatment services available that people  
23 can engage with, we're missing an opportunity to do the  
24 kind of prevention that's really important.

25

26 THE CHAIR: Was Cedar House the same sort of program as  
27 the one you're running privately now?

28

29 MS PRATLEY: No, it was quite different.

30

31 THE CHAIR: Can you just explain to us how it was  
32 different?

33

34 MS PRATLEY: Cedar Cottage was a pre-trial diversion  
35 program and I was actually just about to make the point  
36 around offering incentives for participation and treatment.

37

38 It commenced operation in 1989 and that was following  
39 a finding that these types of offenders just weren't  
40 progressing through the criminal justice system, as other  
41 types, and that's because of all the pressures that  
42 intrafamilial offenders faced around going through that  
43 court process, receiving convictions where victims would  
44 often withdraw their complaints or refuse to take part in  
45 that process because of the dynamics that were present.

46

47 The program offered an incentive, so it was pre-trial



1 diversion. The fathers who were referred to the program  
2 would enter a guilty plea at court and that precluded the  
3 need then for child victims to have to go through that  
4 court process and then instead of a custodial sentence,  
5 they would be sentenced into participation in the program.  
6 They would live independent of their families, have no  
7 contact with their families, until they had reached a point  
8 in treatment where that was assessed as being appropriate  
9 and had to work through those processes to do that.

10

11 THE CHAIR: The program lasted for how long in  
12 Cedar House?

13

14 MS PRATLEY: It was a minimum of two years and people  
15 could apply for an extension up to one year.

16

17 THE CHAIR: Effectively, you were incarcerated for two  
18 years, is that how you should understand it?

19

20 MS PRATLEY: They didn't live at the program site.

21

22 THE CHAIR: But they were required to be there.

23

24 MS PRATLEY: Yes, they were required to be there. If they  
25 didn't attend, if they didn't progress satisfactorily, that  
26 was reported back to the court and they could be removed  
27 from the program. If that happened they would then be  
28 sentenced in court, having already entered a guilty plea,  
29 as if they had never participated in the program.

30

31 THE CHAIR: Could they maintain a normal job while doing  
32 the program?

33

34 MS PRATLEY: Absolutely, yes.

35

36 THE CHAIR: So it was just a restriction in the sense of  
37 an obligation that didn't interfere with their basic  
38 capacity to function in the community; is that correct?

39

40 MS PRATLEY: That's correct, keeping in mind that we had  
41 an expectation that meant that these men would continue  
42 providing financially for their families, so we had quite a  
43 vested interest in them maintaining employment.

44

45 THE CHAIR: Yes. What numbers went through the  
46 Cedar House program?

47

1 PROF GOODMAN-DELAHUNTY: The evaluation was done with a  
2 less than complete set of participants over the life of the  
3 program and we evaluated over 200. My estimate is that in  
4 the life of the program there were probably closer to  
5 300 or more.

6  
7 THE CHAIR: Has anyone else in any other State trialled or  
8 do you have a program similar to that Cedar House program?  
9

10 DR PHARO: In South Australia we have Owenia House which  
11 is run by the Department of Health rather than the  
12 Department of Corrections. I can't speak to the specifics  
13 of that because it is run by a separate department, but it  
14 does address some of the same principles in terms of people  
15 being able to self refer if they have concerns about their  
16 risk of offending in the future and things like that.

17  
18 PROF GOODMAN-DELAHUNTY: Owenia isn't a diversion program,  
19 as I understand it.

20  
21 DR PHARO: No, it's not, not specifically.

22  
23 JUSTICE COATE: So pre-criminal charge?  
24

25 DR PHARO: Typically, yes. There are some individuals who  
26 might be going there during the course and once again, I'm  
27 not the authority on this, I would just kind of preface  
28 that, but there are individuals who will attend during the  
29 course of legal proceedings in the background, but usually  
30 they do it voluntarily rather than being directed by the  
31 court.

32  
33 THE CHAIR: Jessica, apart from Cedar House and your  
34 private work, do you have an opinion about the programs  
35 offered within the prison system as to their effectiveness?  
36

37 MS PRATLEY: No, not in terms of effectiveness. No, I'm  
38 not up to date with that research. I know the programs  
39 that they offer within the custodial setting are quite  
40 similar to the program offered in our private practice in  
41 terms of components, but also in terms of taking that  
42 individualised approach.

43  
44 I do think that one of the benefits of community based  
45 programs is being able to engage with a person's support  
46 network, with their families, but also keep people actively  
47 engaged in the community, which we know lowers risk, as

1 I think Stephen was saying before in terms of engagement in  
2 employment and so forth.

3  
4 THE CHAIR: Stephen?

5  
6 PROF SMALLBONE: If I may, I would like to add a critical  
7 comment to the Cedar Cottage program as an outsider.  
8 I think working with families and taking account of  
9 children's circumstances in the context of an offence or  
10 the offender's circumstances is really a good idea, but as  
11 I understand it as an outsider, the Cedar Cottage program,  
12 as you say, two years, the selection of that group seemed  
13 to me to be based on the idea of having the most compliant  
14 and low-risk people possible to begin with. It also had a  
15 very high drop-out rate and part of the evaluation was  
16 about comparing outcomes for the people who completed with  
17 the people who didn't complete, who presumably had shown  
18 problems along the way, and conclusions were drawn about  
19 the effectiveness based on the idea that people who  
20 complete did better than people who don't. I mean, that's  
21 really quite unsurprising.

22  
23 I think we need to be careful about the way that we  
24 think about the value, again, of resources and so I think  
25 community based programs absolutely have a role here. That  
26 program was longstanding, it probably began before the big  
27 attention came on to the risk needs and responsibility  
28 model and it came from a different philosophy, a social  
29 work philosophy more than a correctional psychology  
30 philosophy, but it operated very differently and there are  
31 other kinds of issues about it that I think needed to be  
32 taken into account in an overall kind of sense of figuring  
33 out whether that's the right thing to do, because I'm not  
34 sure that it is, frankly. For some reasons, yes, but not  
35 for the reasons that are sometimes claimed to have been  
36 useful.

37  
38 THE CHAIR: There is a challenge. Do you want to respond?

39  
40 PROF SMALLBONE: I don't want to insult anybody but  
41 I think we're grown up enough to be critical, I hope.

42  
43 THE CHAIR: I am sure of that. Do you want to respond?

44  
45 PROF GOODMAN-DELAHUNTY: I don't want the discussion here  
46 to really just focus on one particular program. It is an  
47 example of --

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PROF SMALLBONE: No, no, no, it is an evaluation.

PROF GOODMAN-DELAHUNTY: It provides some terrific lessons for what we can learn about how to approach a much larger social issue. I think there are other parallel programs. There was one running in Western Australia that had similar results, with a restorative justice focus, which unfortunately I think now is also closed. There have been other programs in the United States and elsewhere that provide some parallel. I think there are more general lessons to be learned from it.

PROF SMALLBONE: Absolutely.

THE CHAIR: Stephen, you've heard all this debate now. What are your views and how can you help us to try and sort out the answers?

DR WONG: I think a community program is very important and the research has shown repeatedly that a community program tends to have higher efficacy than a custodial program. In particular, a community program that is geared towards the lower risk offenders and also the ones that can be well managed within the community would be very useful. Because in the institution, in custody, there is always tension between sex offenders and non-sexual offenders and non-sexual offenders look down on sex offenders, to put it mildly, and there's a pecking order and within this pecking order, even within sex offenders, the rapists tend to be at the highest level and the child sex abusers at the very low level. Quite often in treatment they may feel very unsafe in terms of disclosing about their offending and engaging in therapy and therefore it makes it much more difficult to carry out treatment in a custodial setting, in particular, with child sex offenders. That is one reason why I think the evidence is showing that there is more efficacy treating in the community than in an institution.

The other point I want to get back to is your earlier point about treatment completion. Treatment completion can mean different things to different people. In some programs people are considered to have completed treatment if all the boxes are ticked, that they have attended so many sessions, they've done their homework, et cetera, et cetera. Really, treatment, forensic treatment, correctional treatment is about risk reduction, so the

1 question I would ask, if I was sitting in the Parole Board  
2 members' chairs, would be, "Tell me to what extent the risk  
3 has been reduced for this person after attending  
4 treatment."  
5

6 In the field there is technology available, tools  
7 available to measure that, so that can be objectively  
8 measured before treatment, during treatment and after  
9 treatment. There would be a much more meaningful, I would  
10 say, way of talking about treatment, progress treatment  
11 improvement, than simply saying that, you know, whether or  
12 not the person has categorically completed or not completed  
13 treatment, and that would also help decision makers in  
14 making decisions about whether or not this person is  
15 suitable for release to the community.  
16

17 THE CHAIR: Are your observations in that respect  
18 applicable across the spectrum, so that the high-risk  
19 offender and the low-risk offender you could approach using  
20 the same tools?  
21

22 DR WONG: Yes, that can be done for a range of sexual  
23 offending. Actually, in a way it is easier to measure  
24 change for a high-risk offender than for a lower-risk  
25 offender because for a lower-risk offender we have the  
26 so-called flow effect, that they're so low there's not much  
27 room for them to move. For high-risk offenders there's  
28 more room for them to move and that's also why the research  
29 is showing it is easier to demonstrate efficacy in a  
30 higher-risk offender than in a lower-risk offender and it's  
31 in a way more like "more bang for your buck" in terms of  
32 putting resources into treating high-risk offenders.  
33

34 THE CHAIR: Does that research tell us that the  
35 measurement, if you like, of effect at the end of the  
36 treatment program, which you say can be quite effective,  
37 that that effect continues thereafter, so that if I'm a  
38 judge and I decide to release because you tell me that the  
39 tool has measured that this has had a significant positive  
40 effect, what's my level of confidence that that will be the  
41 case in two, three or five years time?  
42

43 DR WONG: One thing is there is research showing the  
44 re-offending rate for three years, five years and 10 years,  
45 so that's one way of looking at it. The other thing is no,  
46 there's never a guarantee, in a way, because once a person  
47 is out of custody then, as Stephen has mentioned, the

1 impact of the environment is very important and risk  
2 assessment doesn't really capture that bit very well in  
3 terms of the environmental impact. Because of that, that's  
4 why the community follow up is very important.  
5

6 That said, the research also shows that the bulk of  
7 the re-offending happens between six months to a year, that  
8 is when most of the re-offending happens, so the curve goes  
9 like that, so once the person has gone over that hump then  
10 it's much safer in a way. The test is within that short  
11 period of time.  
12

13 In terms of the community resources, they should be  
14 focused on that time and also in terms of decision making  
15 I would like to hear from treatment providers what the risk  
16 is like and what kind of management strategies are required  
17 and see whether or not the community can provide that to  
18 manage the risk.  
19

20 THE CHAIR: Do I understand correctly that you're  
21 suggesting that although effort in treatment programs  
22 within the prison may not be wasted, we need to consider  
23 for those who may have been imprisoned, treatment programs  
24 out of prison perhaps while they're in their parole period;  
25 is that what you're saying?  
26

27 DR WONG: Yes, follow up is extremely important and risk  
28 management follow up is very important, yes. It is the  
29 continuity care model.  
30

31 THE CHAIR: Does anyone provide an effective program that  
32 allows for that to happen?  
33

34 MS BRADEN: I might perhaps speak broadly in terms of the  
35 risk reduction and then the risk manageability, so doing  
36 that intensive treatment pre-custody and then upon release,  
37 so we engage in that pre-release planning whilst that  
38 prisoner is in custody. The risk manageability strategy  
39 starts at the potential parole eligibility date. We look  
40 at a whole lot of factors around environmental scanning, so  
41 where their proposed address of release will be.  
42

43 What are the risk factors relevant for that particular  
44 individual offender that might pose an increased level of  
45 risk manageability that is not acceptable for the community  
46 if we were to release that person to that particular  
47 environment, or what are their other particular needs that

1 link directly to their offending that we need to take into  
2 consideration as part of that release.

3  
4 We have a very robust case management strategy and  
5 process in place in Victoria that links all those  
6 processes, from assessment, treatment and that release to  
7 the community from both the risk reduction and also the  
8 risk manageability across all levels of their particular  
9 needs, whether it's individual psychological intervention  
10 maintenance programs that we provide or other services  
11 around re-integration back into the community across social  
12 aspects and protective factors, so a big emphasis.

13  
14 One of the protective factors that we can put in place  
15 as part of a department but also as part of the community  
16 once that person has finished that order, that can remain  
17 in place to ensure a greater level of protection for the  
18 community and reduce the likelihood of that person  
19 re-offending.

20  
21 THE CHAIR: As I understand Stephen, Stephen is suggesting  
22 that although treatment in prison may have some value,  
23 treatment outside of the prison system may be of greater  
24 value and you're not offering that.

25  
26 MS BRADEN: We do through the maintenance program. We  
27 wouldn't repeat the same program again and most  
28 jurisdictions don't repeat the same intensive program, but  
29 if we identify through treatment that there are outstanding  
30 treatment needs relating to sexual deviance or intimate  
31 relationships, that's when we will target that particular  
32 treatment for that offender specifically, as opposed to  
33 just replicating the same program that you identified; the  
34 individual treatment needs and target your release planning  
35 to service those particular needs of that offender relating  
36 to both their sexual and social elements.

37  
38 THE CHAIR: Are you suggesting that that's not  
39 appropriate, Stephen, or is that enough as far as you're  
40 concerned?

41  
42 DR WONG: I think that's appropriate, it's entirely  
43 appropriate, and I think treatment in custody is important  
44 because it doesn't make sense to put a person in cold  
45 storage until the person gets out. You have to start the  
46 process of treating the individual. All I'm saying is that  
47 there are a lot of challenges in providing treatment in

1 prison and to maintain program integrity and so on. In a  
2 way you have to work a lot harder in order to get to the  
3 point where you have an expected impact on the offender.  
4

5 THE CHAIR: Do you accept that what Victoria is doing is  
6 then adequate upon release?  
7

8 DR WONG: Yes. From what I hear I think that the risk  
9 management process, giving the community, the people, an  
10 idea how to manage the person, what are the things to focus  
11 on and continuing to support the improvement, yes, it's  
12 entirely appropriate.  
13

14 THE CHAIR: Yes. The way we talk of course in this  
15 gathering, for someone who was a layperson listening in  
16 they may think that we're able to express a level of  
17 confidence that makes these people safe, but that I assume  
18 is not what you would necessarily say about every  
19 individual; is that right?  
20

21 MS BRADEN: Correct.  
22

23 THE CHAIR: Yes. Henry, I think you wanted to say  
24 something.  
25

26 DR PHARO: I wanted to make a very quick comment which is  
27 this notion that rehabilitation going through into the  
28 community is more than just ongoing classroom environment  
29 programs that we've been talking about in terms of what we  
30 do in prison. I think it is important for the discussion  
31 to consider all of these things that are important and if  
32 we look at the desistance literature, it shows that  
33 cognitive shift is one thing, so changes in people's  
34 thoughts is really important and I think that can be  
35 achieved through prison programs, but those people who do  
36 successfully avoid re-offending in the community are those  
37 who are able to actually re-integrate with society,  
38 maintain employment, establish social connections with  
39 their community and things like that.  
40

41 I just think it is important to consider programs in  
42 the community as being more than just them needing to come  
43 along to attend a maintenance program. It is that  
44 whole-of-systems approach again that we're talking about.  
45

46 MS DONALDSON: Part of that is also then that level and  
47 balancing that level of supervision and monitoring as well.



1 As you would be aware, your Honour, the highest risk  
2 offenders in this State and in other jurisdictions can be  
3 subject to electronic monitoring, weekly schedules, you  
4 know, where Corrective Services are also vetting or  
5 screening the people that they're associating with,  
6 relationships that they're forming in places of employment  
7 as well as accommodation.

8  
9 At that highest risk level there is a high intensity  
10 of monitoring and supervision as well as that continuing to  
11 participate in programs, and then also trying to balance  
12 re-integrating these men back into the community with that  
13 high level of monitoring as well is always a difficult  
14 thing.

15  
16 THE CHAIR: I have often wondered - I've never had someone  
17 to ask but I am going to ask you now - does the electronic  
18 monitoring actually do much in the way of assisting you to  
19 avoid people re-offending?

20  
21 MS DONALDSON: I am not aware of the data on that  
22 personally. I am not sure, Jason, if you're aware of how  
23 effective the electronic monitoring - I could speak  
24 anecdotally but I'm not sure if you're aware of --

25  
26 MR WARE: We haven't expressed a lot of confidence that it  
27 would necessarily reduce someone's re-offending. It might  
28 tell us where they were.

29  
30 THE CHAIR: Yes, it does, where they've been, yes.

31  
32 MR WARE: My understanding of the research from some time  
33 ago was that it didn't actually show that much impact of  
34 having electronic bracelets, by themselves. Again, I think  
35 what we're all arguing is that there needs to be a multiple  
36 aspect or aspects to any planning to support some  
37 individual into the future.

38  
39 THE CHAIR: There is one very big issue in the room that  
40 we haven't talked about yet. Louise, it's the one that I'm  
41 going to ask you to talk about. The system, as you know,  
42 although we have been pleading for a national approach,  
43 provides for a capacity to engage in a checking process;  
44 the Working With Children Check it's called. Again,  
45 I stress that we have recommended a national approach and  
46 we can't see why there is any reason that that should not  
47 be done. It seems to us to be the most obvious of

1 solutions when you have a country where people move  
2 constantly across state borders and move employers in the  
3 same field across state borders.  
4

5 What of course is relevant for today's discussion is  
6 given that people will offend in an institutional context,  
7 they may be trained as teachers or some other provider in  
8 an institution, they offend, they are treated and then of  
9 course released. Having been treated is there any room to  
10 make a decision that would allow for such a person to go  
11 back into the institutional environment in which they  
12 offended?  
13

14 MS COE: Firstly, the New South Wales Working With  
15 Children Check system is a protective regime and the  
16 paramount considerations are the safety and wellbeing of  
17 the children. In that context, if a person had a  
18 conviction for a sex offence, whether it is a child sex  
19 offence or an offence against an adult, the first question  
20 we would be asking is why they would be seeking to put  
21 themselves in the vulnerable position of working with  
22 children.  
23

24 I think, as Professor Smallbone said, the risk  
25 management component is important in this context, but if  
26 they could get over that hurdle and they applied for a  
27 Working With Children Check, if they had a conviction they  
28 would be automatically barred which means they would be  
29 determined as a disqualified person. Automatically,  
30 they're prohibited from working with children and for them  
31 to appeal that decision they would have to apply to the New  
32 South Wales Civil and Administrative Tribunal for an  
33 enabling order which could be granted to enable them to  
34 work with children.  
35

36 Given that context, there are certain offences where  
37 there are no appeal rights or limited appeal rights and in  
38 November last year the New South Wales Government expanded  
39 the category of offences where there is limited appeal  
40 rights, which means persons convicted of murder, sexual  
41 offences against a child, pornography offences or incest  
42 offences, where there has been a custodial sentence or  
43 there has been a control order which has not expired, they  
44 cannot appeal to have that decision reviewed.  
45

46 In that context we have had I think 140 NCAT decisions  
47 since the new scheme started in June 2013. Of those 140

1 there were 83 which were appeals from automatically  
2 disqualifying offences, so they are people who have  
3 convictions, and of those matters we are not aware of any  
4 decisions of NCAT where they have determined that the  
5 participation in a sex offender or intervention program has  
6 been a persuasive factor in granting an enabling order.  
7

8 We are aware that there are three matters where there  
9 was evidence the applicant had engaged in a sex offending  
10 program where NCAT had still refused to grant an enabling  
11 order or a clearance and in those three matters the more  
12 persuasive factor was that the applicant had made  
13 admissions in one matter that he still continued to have  
14 fantasies, there was a lack of insight in another matter  
15 and given the seriousness of the offence in the third  
16 matter, the Tribunal member did not think it ameliorated  
17 the risk to children.  
18

19 In that context, also in 2014, to inform our  
20 decision-making process, we engaged the Australian  
21 Institute of Criminology to conduct a literature review  
22 that would inform how we made decisions and one of the  
23 terms of reference was whether there was any research on  
24 the effectiveness of treatment programs and the outcome of  
25 that was that the literature that they examined at that  
26 time identified that there were very few methodologically  
27 rigorous evaluations of programs for either sex or violent  
28 offenders and on that basis they couldn't comment on the  
29 effectiveness of such programs.  
30

31 While we would consider that there has been positive  
32 engagement in a treatment program, there are a number of  
33 other factors which may weigh more heavily on whether  
34 someone should be granted a clearance or not, but as we've  
35 said, if someone has engaged in sex offender programs they  
36 must have a conviction and when we conduct a risk  
37 assessment at the Office of the Children's Guardian, we  
38 don't look at those convicted sex offenders, we're looking  
39 at people that may have charges or may have a workplace  
40 finding, a sustained workplace finding that there was  
41 sexual misconduct.  
42

43 There was one matter where it was a sustained finding,  
44 although there were no criminal matter charges where he'd  
45 engaged in a denial program. That went on appeal to NCAT  
46 and in that case NCAT weren't persuaded that the program  
47 was successful. He didn't get to complete the program, as

1 I understand, and there were still overriding concerns.  
2  
3 THE CHAIR: I'm not sure I'm understanding all of that,  
4 but do I understand that, for a time, you could appeal your  
5 decision even if you had a conviction for a sexual offence?  
6  
7 MS COE: Some offences are still appellable to --  
8  
9 THE CHAIR: Sexual offences?  
10  
11 MS COE: Sexual offences, yes.  
12  
13 THE CHAIR: Some are still appellable?  
14  
15 MS COE: Yes.  
16  
17 THE CHAIR: But is that a minority? Are most of them now  
18 not appellable?  
19  
20 MS COE: There is a large majority that aren't appellable,  
21 but the rider is that they have received a custodial  
22 sentence.  
23  
24 THE CHAIR: So it has to be a sex offence that has  
25 a custodial sentence, and then there is no right of appeal;  
26 they are out.  
27  
28 MS COE: That's correct.  
29  
30 THE CHAIR: If you have committed a sexual offence but  
31 have received a bond or suspended sentence, does that rule  
32 you out?  
33  
34 MS COE: No. You are only ruled out if the period of the  
35 control order has not expired. So if you had a two-year  
36 suspended sentence, for that two years, post that sentence,  
37 you could not appeal the decision.  
38  
39 THE CHAIR: So a suspended sentence, for this discussion,  
40 is not considered to be a custodial sentence?  
41  
42 MS COE: That's correct.  
43  
44 THE CHAIR: And in that event, your decision, if someone  
45 has had a suspended sentence and, say, gone to Jessica's  
46 program - would your decision as to whether or not to grant  
47 them a Working With Children Check clearance be influenced

1 by the fact that they have completed a program with  
2 Jessica?  
3  
4 MS COE: There are a number of factors we would consider.  
5 That would be a positive factor.  
6  
7 THE CHAIR: So you would take that into account?  
8  
9 MS COE: We would consider it, but there would be other  
10 considerations which might outweigh that participation.  
11  
12 THE CHAIR: Right. But you don't, as it were, write off  
13 Jessica's work; you accept that it may contribute  
14 positively to the person's future behaviour?  
15  
16 MS COE: That's correct. But, as I said, in our risk  
17 assessments that we conduct, because we don't look at the  
18 adult convicted offenders, we wouldn't have evidence - we  
19 don't have evidence of applicants having engaged in a sex  
20 offender program. They might have engaged in other  
21 programs, such as drug and alcohol or substance abuse  
22 programs, domestic violence programs, which we would  
23 consider, but when we conduct a risk assessment, we haven't  
24 had any situations where there is someone who has completed  
25 a sex offending program, because in the risk assessment, we  
26 are looking at the non-conviction charges.  
27  
28 THE CHAIR: Right. Well, then, can I throw it to  
29 everyone - those who evaluate and those who operate, if  
30 I can put it that way: what is the view, if someone has  
31 committed a sexual offence and been incarcerated, and has  
32 gone through the treatment program and they are engaged in  
33 a community assistance program after release - should they  
34 ever be allowed to work with children, if the offence was  
35 in the context of children? There are a couple of shaking  
36 heads. Does anyone say they should ever be allowed to?  
37  
38 MR WONG: In sex offender treatment, obviously, it is not  
39 about cure, it is about managing risk, teaching the person  
40 to manage risk. One of the often-used things to get them  
41 to learn is about avoiding high-risk situations. That is,  
42 you don't get yourself sort of being drawn into situations  
43 where there are children around, for example, even an  
44 apparently innocuous situation like walking by a playground  
45 or hanging around in arcades, and so on, where there are  
46 children. So, now, if this is part of the person's risk  
47 factor when the person is in treatment, obviously, it has

1 to be continued on.

2

3 So if a person has that profile and comes to me and  
4 says, "I would like to apply for a job to work with  
5 children", then I would have a lot of questions to ask  
6 about: "Why would you want to do that?" "Why would you  
7 want to put yourself again in a risky situation, when you  
8 have already been told, 'Don't do that'?"

9

10 THE CHAIR: Yes. What it means - and this has been  
11 a theme, I think, through the morning - is that we need to  
12 actually see treatment in a slightly different context to  
13 the way we would often use that word in other contexts.

14

15 MS SWAN: That's right.

16

17 MS DONALDSON: Yes.

18

19 THE CHAIR: Because, as I understand it, what you are  
20 ultimately saying is that the treatment is a program which  
21 is designed to enable people to order their own behavioural  
22 processes so as not to expose themselves to the risk which  
23 they have previously succumbed to. Is that what we are  
24 really saying?

25

26 MR PHELAN: We define treatment as a starting point. At  
27 no point is it considered an end point. It is a starting  
28 point.

29

30 If we had a teacher who may generally have an interest  
31 in teaching, then there are many cohorts that that person  
32 can teach to and it doesn't necessarily have to be  
33 children. I would be concerned with a teacher, who was  
34 a child sex offender, who specifically wanted to teach with  
35 children. If your passion was teaching, there are many  
36 avenues in which you can still engage in your profession or  
37 your passion, which could be teaching adults, for instance.  
38 So we would be very concerned.

39

40 THE CHAIR: Now, the problem becomes, for us, far more  
41 complex than what we have presented so far, because there  
42 are a range of community-based activities where parents  
43 volunteer but, of course, come into regular contact with  
44 children - and they may be parents of their own children -  
45 and you need someone to manage the gear for the cricket  
46 team or someone to score for the cricket team, or so on.

47

1 In those jurisdictions where, at that level of  
2 activity, a Working With Children Check may be required,  
3 which New South Wales, I think, extends to that area, what  
4 do we do? Do we say no to a Working With Children Check  
5 for the offender who has been through a program and  
6 volunteers to manage the under-12 cricket team?  
7

8 MS SWAN: I think we say no. But the other part about  
9 this - and I understand you have another roundtable around  
10 this - as others have said, those people who have had  
11 convictions in terms of child sex offending should not be  
12 volunteering in that capacity. That is an environment that  
13 exposes them to risk.  
14

15 THE CHAIR: Well, they will turn up to watch their own  
16 child play.  
17

18 MS SWAN: They will. But I guess the Working With  
19 Children Check is one element of what organisations that  
20 have children or are responsible for children must do,  
21 because we know the conviction rates are extremely low of  
22 sex offenders, and all sex offenders have a first offence,  
23 so even if we were to identify all those convicted and stop  
24 them - however difficult, I accept, that that might be - we  
25 still have new offenders and those who have not been  
26 convicted. So we need to then look at how we create child  
27 safe environments, and there are others who have more  
28 expertise than I around that.  
29

30 So, again, as complex as all these things are, as you  
31 know better than me, there need to be multiple approaches  
32 by which we keep our children safe within communities. So  
33 one is the check and to be kind of rigorous in how we do  
34 that, and we, from the side of perpetrators, need to be  
35 complete in how we monitor and treat and other aspects that  
36 we have talked about today, but we also need to have the  
37 broader community mindful of how do we construct  
38 environments where we have children that have as much  
39 freedom as we can allow them to have safely, but that we  
40 have checks in place to make sure that new perpetration or  
41 those who are not convicted are not allowed to go  
42 unchecked.  
43

44 MS COE: Can I just say that while we do also run the  
45 Working With Children Check, we have our Child Safe  
46 Organisations strategy and we are very clear, and have  
47 always been firmly of the view, that a Working With

1 Children Check should not be your sole risk-mitigation  
2 strategy, and that there are other things, simple things,  
3 that organisations can do that can keep children safe.  
4

5 PROF SMALLBONE: I did some work with the New South Wales  
6 Children's Commission back about 10 years or so ago. At  
7 that stage, the ideas around the Working With Children  
8 Check I thought were really interesting. That system  
9 originally accounted for variations across people, but also  
10 variations across the circumstances that might constitute  
11 risk. And so the original model, as I understand it, was  
12 that a Working With Children Check permission was not  
13 transferrable from one role to another --  
14

15 MS COE: Correct.  
16

17 PROF SMALLBONE: -- but was considered in terms of the  
18 specific role that the person was asking to be involved  
19 with.  
20

21 So if the role involved unsupervised contact with  
22 highly vulnerable children, and also in an organisation  
23 that didn't have its act together very well in terms of  
24 conceptualising its risk and managing it, then the  
25 threshold for the offender became much, much higher. But  
26 there could be lower thresholds for the offender risk in  
27 other kinds of circumstances.  
28

29 I think conceptually that makes a whole lot of sense  
30 to me but I understand that, in practice, that can be very  
31 complicated to organise.  
32

33 But the idea of having a transferrable check so that  
34 once you were able to work with children you could do  
35 anything with children I think is really problematic,  
36 because there is a vast range of circumstances in which  
37 that might operate.  
38

39 MS PRATLEY: I was just going to add that it is very  
40 difficult to answer your question in one way, because there  
41 is, as we have talked about, so much variability. In terms  
42 of the Working With Children Check, while it covers  
43 employment, it covers those volunteer positions, it also  
44 covers people who, through circumstances not necessarily of  
45 their own seeking, may be in a position where they are  
46 having to care for children, family members, and that may  
47 be through, say, a FACS process, where they need to apply



1 for a Working With Children Check.

2

3 I think that it is really important that an individual  
4 approach is taken, an individual risk assessment process is  
5 taken, where it is not just looking at whether they are  
6 engaged in treatment but also looking at the particulars of  
7 the offending behaviour, looking at how much time has  
8 passed. I know these are all points covered by the NCAT  
9 process, but it is really difficult to make a blanket rule,  
10 because nobody sort of fits into a neat box.

11

12 THE CHAIR: But everyone is saying, as I understand it,  
13 two things, really: treatment should be seen as  
14 a potential positive for anyone, but it should never be  
15 assumed that treatment is a cure. Is that correct?

16

17 MS DONALDSON: Correct.

18

19 THE CHAIR: Is that where we end up?

20

21 (There was agreement from multiple speakers at the table)

22

23 THE CHAIR: So we might be able to fix the flu but we  
24 can't put sexual offending in the same category. Is that  
25 where we end up?

26

27 MS DONALDSON: Yes.

28

29 MR PHELAN: Yes.

30

31 THE CHAIR: Leigh, is there more that we need to tax these  
32 people with?

33

34 MS SANDERSON: No.

35

36 THE CHAIR: Thank you, all.

37

38 DR WONG: In terms of the last question about community  
39 volunteering situations, even if we bar everybody who has  
40 a conviction from working with children, there would be  
41 lots of other people that we don't know about, that are  
42 under the radar, and those people will still be there in  
43 the community.

44

45 I think perhaps one of the strongest ways of keeping  
46 children safe is to make sure that all of us who observe  
47 are willing to talk about when we see something not

1 appropriate, and that applies to, you know, other parents  
2 also there, when they see something.

3  
4 Sex offenders usually don't go and re-offend like  
5 that, they go through a process of grooming and other  
6 things. So there is lots of opportunity to observe, and  
7 also to reduce the risk by sharing information among people  
8 in that situation.

9  
10 THE CHAIR: You are absolutely right. But one of the  
11 confounders in all of this, I suspect for all of you, is  
12 the assumption, which seems to be fairly correct, that this  
13 sort of offence is significantly underreported, so we just  
14 don't know exactly what is happening, and, indeed, we don't  
15 know what's happening with offenders who have been treated,  
16 in the true sense, because we don't know whether there may  
17 be unreported offending there as well.

18  
19 Can I make the assumption that we are all done? Well,  
20 can I thank you all for the contribution you have made  
21 today. All of our roundtables are immensely important for  
22 us, and we are very grateful that you have all given of  
23 your time to engage with us to help us in what is an  
24 enormous task, covering so many areas of society that  
25 interrelate with the problem that we were given by the  
26 governments. But without the help of all of you and others  
27 like you, I'm sure we wouldn't be able to complete our work  
28 in a satisfactory way.

29  
30 Thank you, and we look forward to seeing you all again  
31 in different ways as we do our work. Thanks again.

32  
33 AT 12.59PM THE PUBLIC ROUNDTABLE WAS ADJOURNED ACCORDINGLY  
34  
35  
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