



NHS National Programme on Forensic
Mental Health Research and
Development

Expert Paper:
Sex Offender Research

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National R&D Programme on Forensic Mental Health

The National Programme on Forensic Mental Health R&D was established in April 1999. It has built on the work of the R&D Programme set up as part of the High Security Psychiatric Services Commissioning Board, which was first established in September 1996. The Programme's remit is to develop the evidence base of mental health services for mentally disordered offenders in a range of NHS settings

An Advisory Group informs the Programme on the commissioning, dissemination and implementation of R&D in this area. In April 2000 and early 2002 this group commissioned expert papers to be written covering the categories identified from an earlier priority question setting exercise undertaken by representatives of key stakeholder groups.

This report is one of a series covering:

- Antisocial Personality Disorder : Children and Adolescents
- Dual Diagnosis of Mental Disorder and Substance Misuse
- Prison Healthcare
- Social Division and Difference : Black and Ethnic Minorities
- Sex Offenders Research
- Social Division and Difference : Women
- Mental Illness and Serious Harm to Others
- Personality Disorder (commissioned 2002)
- Neurobiological approaches to Disorders of Personality (commissioned 2002)
- User involvement in Forensic Mental Health R&D (commissioned 2002)

These papers were written to provide an overview of ongoing and completed research in addition to proposing a future programme of research. They include the following:

- An overview of ongoing and completed research
- Identification of the gaps in knowledge which should include consideration of the research questions proposed by stakeholders in the priority question setting exercise;
- Formulation and prioritisation of three research questions;
- Any recommendations for achieving more effective commissioning of research (eg. Identification of appropriate publications relevant to the topic area for advertising funding opportunities).

The views expressed in this publication are those of the authors and not necessarily those of the National R&D Programme Forensic Mental Health, the Advisory Group, or the Department of Health.

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Executive Summary

This paper provides a summary of the current state of research in relation to sex offending. Its focus is primarily on those areas where researchers are active, or where they arguably should be. It is organised into six topic areas identified by the National Programme on Forensic Mental Health Research and Development, with the central research issues in each outlined. The paper concludes with recommendations for three research questions to be given priority, and on the effective commissioning of research.

Central research issues

Epidemiology

Of particular relevance to forensic mental health is the prevalence of sexual psychopathologies that underlie sexual offending. Our lack of knowledge about base rates of sexually deviant behaviour, and of sexual psychopathology in general, has important implications for practice. It is not uncommon for individuals to present in forensic clinics describing deviant sexual fantasies, or problematic deviant sexual behaviour, but valid risk assessment is impossible in the absence of a better understanding of the base rates of these types of phenomena in the community, among supposedly normal individuals.

Identification and diagnosis

Assessment of non-offenders

Recent attention has focused on ways of evaluating sexual interest by means other than self-report or penile plethysmography. The use of psychometric and psychophysiological measures has been explored, but both measures are still in their early stages. Research protocols designed to produce a package of clinical interview, psychometric testing and psychophysiological measures capable of identifying individuals who are a potential sexual risk to children (and other vulnerable victims) should be possible to develop.

Supervising known sex offenders in the community

Rating scales developed to assist in the detection of changes in risk are currently under evaluation. In the United States polygraphy (i.e. the lie detector) is also widely used, but well designed studies and controlled trials are lacking.

Diagnosis

There are two aspects of diagnosis relevant to this paper. The first is in respect of sexual deviance, where we lack the means with which to make reliable diagnoses of the sexual paraphilias. The second relates not to sexual disorders themselves, but to other

conditions that have an impact on sexual offending. In particular there is the question of personality disorder. We have little idea how many sex offenders suffer from personality disorder, or indeed mental illnesses (psychotic or otherwise), or how these conditions might interact with their offending. This is of some relevance given that many of those who are seen as potential candidates for 'Dangerous Severe Personality Disorder' detention orders appear to be sex offenders. A basic research question that could be readily addressed in both the prison and probation services is: what is the diagnostic profile of sex offenders within the criminal justice system?

Risk assessment

There is currently a good deal of research taking place into sex offender risk assessment, both in the United Kingdom (UK) and North America. Initially the emphasis was on actuarial measures, using static risk factors, and there are now a number of tools with varying levels of validity. These scales successfully identify and quantify low, medium and higher risk groups of offenders, but application to individual offenders is difficult. More recently, dynamic risk factors that do relate to individuals as opposed to groups have attracted research interest, making use of both psychometric batteries and more clinically oriented assessments. A major problem in evaluating this work, however, is the dependence of such studies on reconvictions, which are known to underestimate true re-offending. Research that developed ways of overcoming this problem would be welcome.

Treatment

Data is steadily increasing in this area, and though studies are of variable quality, reviews and meta-analyses tend to conclude that evidence of efficacy has only been demonstrated for cognitive-behavioural type programmes, and for anti-libidinal medication (in conjunction with psychotherapy). More data relating to cognitive-behavioural interventions is needed.

While cognitive-behavioural programmes still need to prove themselves, the winds are at least encouraging. This is not the case for psychodynamic-type approaches, which are still common in the National Health Service (NHS). Here, what evidence there is suggests that, if anything, psychodynamic psychotherapy may make offenders worse. Given the persistence of psychodynamic psychotherapy in the treatment of sex offenders within the Health Service, there is a clear research need to establish whether or not such an approach has anything to offer in the treatment of sex offenders. (Romero, J.J., and Williams, L.M., (1983) Borduin, C., Henggeler, S., Blaske, D., and Stein R.(1980))

Drug treatment

Unlike psychotherapy, drug treatments are amenable to randomised, controlled trials, and it is of interest that virtually none exists. Until the last few years, the main types of pharmacological treatment were anti-libidinal medication - cyproterone acetate in the UK and Canada, and Depo-Provera in the United States. A recent study claimed that triptorelin (a drug which blocks the secretion of gonadotropin-releasing hormone) brought

about a marked reduction in sexual fantasies and sexual drive, with fewer side effects than are normally reported with cyproterone or Depo-Provera. Another development has been the use of selective serotonin re-uptake inhibitors (SSRIs) such as fluoxetine (Prozac) in the treatment of sex offenders. Some claim that these drugs produce a selective reduction in deviant fantasy and arousal, with a reduction in offending.

Service delivery

There have been two main developments in respect of service delivery in the UK. The first relates to the establishment of a system of accreditation for all offending behaviour treatment programmes offered in the probation and prison services, with the intention of ensuring that they are evidence-based, and are delivered in a manner that preserves treatment integrity. Although accreditation is now part of Home Office policy, it does have its critics. The effect of accreditation on service delivery is a real issue, and one that itself should be the subject of research evaluation.

The second relevant development is the emergence of multi-agency risk panels in which the police and probation services take the lead in determining the risk of sex offenders in the community, and formulate management plans. Health providers have been involved only uncomfortably with this, and research that has been carried out has not looked to any extent at the way in which forensic mental health, and indeed general psychiatric, services interact with these panels.

Professional development

One possible line of enquiry here is the identification of the components that characterise successful training programmes aimed at those wanting to work with sex offenders.

Three high-priority research questions

In prioritising questions for research, those most relevant to forensic mental health, and which require forensic mental health expertise, have been emphasised:

1. the efficacy of pharmacological treatments in alleviating sexual psychopathology and reducing sexual offending

In relation to this there are two treatment approaches that I suggest should be evaluated:

- the use of SSRIs

- a comparison of the antiliberidinal medications cyproterone acetate and triptorelin.
2. diagnoses in sex offenders

Again there are two issues to be examined:

- whether more reliable and valid ways of diagnosing paraphilias can be developed
 - the prevalence of mental illness and personality disorder among convicted sex offenders.
3. whether psychodynamic and related psychotherapies have anything to offer in the treatment of sex offenders.

Effective commissioning of research

Sex offending is a fairly specialised area, and I believe that commissioning of research will be most effective if it is targeted primarily at those with the relevant expertise. In addition to invited tenders, the other avenue into those with relevant experience is through NOTA (the National Organisation for the Treatment of Abusers), which is an active and well organised group with a large membership; the majority of those in the UK with a research interest in sex offenders are members. It has its own journal as well as a newsletter, through which opportunities can readily be advertised.

1. Introduction

Our knowledge about sex offenders and sex offending has increased substantially over the last ten years. Demographic and psychometric characteristics of sex offenders are now reasonably well described (Grubin, 1998; Hudson and Ward, 1997), the principles of treatment are better understood (Marshall, Anderson and Fernandez, 1999), and there are now a number of risk assessment approaches and instruments that appear to have good validity (Hanson, 2000). Research-based aetiological theories have even started to emerge (Marshall and Barbaree, 1991; Ward, Hudson and Keenan, 1998). In the UK, the situation has now reached the stage where three sex offender treatment programmes, two run by the prison service and one in probation, have been able to meet the strict accreditation criteria established by the Home Office Offending Behaviour Programme Accreditation Panel.

Two main features of this progress in the sex offender world need to be recognised. First, for a variety of reasons, little has occurred within the context of the so-called gold standard of randomised, double-blind controlled trials; this is particularly relevant to treatment issues, and was reflected in a recent systematic review of sex offender management partly funded by the High Security Psychiatric Services Commissioning Board (White et al, 1998). Second, these advances have occurred largely outside forensic mental health settings, and have not universally seeped into them. This means that not only do forensic mental health clinicians tend to lag behind practitioners working in other areas (particularly those in the criminal justice system), but also that issues less related to re-offending and immediate public safety considerations may thereby be neglected.

This paper aims to provide a general overview of the research scene in each of the areas identified by the National Programme on Forensic Mental Health Research and Development (even where no specific questions emerged from the preliminary survey of stakeholders):

- epidemiology (Section 3)
- identification and diagnosis (Section 4)
- risk assessment (Section 5)
- treatment (Section 6)
- service delivery (Section 7)
- professional development (Section 8).

The three research questions chosen for formulation and prioritisation, however, focus on issues most relevant to a forensic mental health research programme.

2. Epidemiology

No questions were identified in the stakeholder survey in what is a potentially interesting area. Much of the relevant epidemiological work has been in the form of victim surveys, which date back to the Kinsey studies of the 1940s, but research based on the records of child protection agencies has also been carried out. This type of approach provides an estimate of the prevalence of sex offending in the community, although the four-yearly British Crime Survey is able to give an indication of incidence in relation to sexual offences against adults.

Victim surveys demonstrate clearly that there are many more sexual offences than there are convicted sexual offenders to account for them. In terms of sexual offences against children, I calculated a range of possible incidence based on data from a variety of sources. I concluded that the annual incidence of children sexually abused per year in England and Wales could be anywhere between 3,500 and 72,600, the lower figure representing the annual number of actual convictions and cautions (Grubin, 1998). A similar exercise could be carried out in relation to adult rape, although here definitional problems create substantial difficulties in interpretation; any sexual activity with a child is an offence, whereas one needs to distinguish between consent and coercion in respect of adult victims.

From a forensic mental health perspective, information about incidence and prevalence is of indirect interest only. More directly relevant is the prevalence of underlying sexual psychopathologies that can (but do not necessarily) lead to sexual offences, such as paedophilia or sadism. Sadistic fantasies, for example, are known to be extremely common among males (Crepault and Couture, 1980), and up to 20 per cent of pornographic magazines in the United States are reported to feature sadistic themes (Dietz and Evans, 1982), but the relationship between this and sexual deviancy, or indeed paraphilia, is unclear. The prevalence of sexual psychopathology associated with other types of sexual offending, such as stalking, voyeurism, frotteurism or indecent exposure, is less understood still, even though these behaviours and offences are common. An interesting survey of British nurses, for instance, found that 44 per cent reported that they had been the victims of indecent exposure in a setting outside work (Gittleston, Eacott and Mehta, 1978), while in an unpublished MPhil thesis on stalking, Claire Berkeley found that about a half of the university students she surveyed admitted to what amounted to stalking behaviour at some time, with women reporting by far more such behaviours than men. In addition, about a third of her sample said they had been the target of such behaviours themselves, usually following the end of a relationship.

Our lack of knowledge about base rates of sexually deviant behaviour, and of sexual psychopathology in general, has important implications for practice. It is not uncommon for individuals to present in forensic clinics describing deviant sexual fantasies, or problematic deviant sexual behaviour (such as stalking), but valid risk assessment is impossible in the absence of a better understanding of the base rates of these types of phenomenon in the community among supposedly normal individuals. Similarly, conclusions about the links between sexual psychopathology and behaviour become skewed when all that we have information about are those that go on to offend. In terms of research, therefore, epidemiological studies addressing these questions could be of great interest

3. Identification and Diagnosis

3.1 Identification

The 'identification' of sex offenders can relate to two issues: the assessment of those who are seeking work that would give them privileged access to potential victims (primarily children), and techniques to monitor and supervise known offenders in the community. There has been a limited amount of research relating to both these areas.

Assessment of non-offenders

Currently the primary means of assessing those who seek to work with potentially vulnerable individuals is by way of checks on the individual's criminal record, although references from previous employers are also sought. Clearly this does little to detect those who have offended but who have not been caught, or those who have not yet offended but are at risk of doing so if circumstances are right. This is a major issue for the Department of Health (e.g. Report of the Committee of Inquiry, 1992), and the Department of Education in relation to its List 99, but as yet there has been little research directed towards this.

One approach has been to look at ways of evaluating sexual interest by means other than self-report or penile plethysmography. To this end, the STEP (Sex Offender Treatment Evaluation Project, sponsored by the Home Office) team has developed a psychometric battery that they claim may identify a 'deviant profile' predictive of re-offending by those who sexually offend against children (Beech, 1998; Allam, 2000). They are now looking at the extent to which this profile might also be an indication of risk of offending in individuals who are not known to be offenders. Relevant studies, however, have not yet been carried out, and nothing has been published, but it seems to be a method worth pursuing. I understand that the Scottish Office has shown some interest in this.

Another approach is to look at psychophysiological-type assessments. The best known of these is the Abel Screen, developed by Gene Abel in the United States. This is essentially based on a comparison of gaze time in relation to photographs of children, adults, and neutral subjects, but does not involve sexually explicit material (Abel et al, 1998). This technique is both controversial (in that evidence of its efficacy is not clear-cut), and expensive. In the UK, other forms of computer-based cognitive processing measures are being advocated (for example by Anthony Beech of the STEP team, and by David Glasgow), but these are still very much in the early stages.

Detecting potential abusers is an important area, but from a research perspective it is one with numerous methodological and ethical difficulties. However, research protocols designed to produce a package of clinical interview, psychometric testing and psychophysiological measures capable of identifying individuals who are a potential sexual risk to children (and other vulnerable victims) should be possible to develop.

Supervising known sex offenders in the community

Karl Hanson in Canada has looked at indicators of re-offending in sex offenders while on probation or parole. The focus has been on so-called dynamic, or changeable, risk factors which can indicate when risk of re-offending is increased - in particular, a 'change for the worse' is looked for (Hanson and Harris, 1998). Hanson has gone on to develop an instrument called SONAR (the Sex Offender Need Assessment Rating) for use in such settings (Hanson and Harris, 2000), the efficacy of which is currently being evaluated.

Another approach widely used in the United States is polygraphy (i.e. the lie detector). There are claims that offenders who undergo regular supervisory polygraphs to detect breaches in their probation or parole conditions (not re-offending per se) have low rates of reconviction (Abrams and Ogard, 1986), but well designed studies and controlled trials are lacking. A research proposal is currently pending with the Home Office to test the efficacy of polygraphy as an aid to the supervision of sex offenders in the community when used as part of a sex offender treatment programme.

3.2 Diagnosis

There are two aspects of diagnosis relevant to this paper. The first is in respect of sexual deviance. The fundamental problem is that we lack the means with which to make reliable diagnoses of the sexual paraphilias. Just as the ability to research into conditions such as schizophrenia improved markedly with the development of agreed diagnostic criteria, so too would research into sex offending be advanced by a better formulation of the paraphilias than currently exists in either the International Classification of Diseases, or the Diagnostic and Statistical Manual of Mental Disorders, as well as by the development of tools to make these diagnoses. Paedophilia and child sexual abuse, for example, are not the same thing, and it is likely to be the case that the two will require different forms of treatment input.

The second diagnostic issue relates not to sexual disorders themselves, but to other conditions that have an impact on sexual offending. In particular, there is the question of personality disorder. Because the lead in sex-offending work has been taken by those working outside forensic mental health settings, personality disorder (and mental illness) are looked for only in the extreme, usually in relation to exclusion criteria for treatment programmes. At present, approximately 700 sex offenders are assessed and treated in the English national prison Sex Offender Treatment Programme (SOTP), but hardly any are psychiatrically assessed. Similarly, OAsys (Offender Assessment System, a structured assessment in the final stages of development by the probation service, intended to form the basis of all pre-sentence reports) does not, for obvious reasons, seek to make clinical diagnoses. The result is that we do not know how many sex offenders actually suffer from personality disorder or mental illnesses (psychotic or otherwise), or how these conditions might interact with their offending. This is of some relevance given that many of those who are seen as potential candidates for 'Dangerous Severe Personality Disorder' detention orders appear to be sex offenders.

A basic research question that could be readily addressed, therefore, in both the prison and probation services, is the diagnostic profile of sex offenders within the criminal justice system.

4. Risk Assessment

There is currently a good deal of research taking place into sex offender risk assessment, both in the UK and in North America (well reviewed in a short pamphlet by Hanson, 2000). Initially the focus was on actuarial measures using static risk factors, and there are a number of tools with varying levels of validity: SACJ (Structured Anchored Clinical Judgement), RRASOR (Rapid Risk Assessment of Sex Offender Recidivism), Static-99, MnSOST (Minnesota Sex Offender Screening Test - Revised), SORAG (Sex Offenders Risk Appraisal Guide) and Risk Matrix 2000, SVR-20 (Sexual Violence Risk - 20) to name the most prominent.

These scales successfully identify and quantify low, medium and higher risk groups of offenders, but application to individual offenders is difficult. More recently, therefore, dynamic risk factors that do relate to individuals as opposed to groups have attracted research interest, partly in an attempt to measure current rather than historical risk, and partly in order to provide a proxy measure of treatment success that does not need to wait for long-term reconviction data. The 'deviancy scale' produced by the STEP psychometric measures, mentioned above, is one example of this, resulting in what is referred to as a 'treated' or 'untreated' profile. More akin to clinical assessment, SRA (Structured Risk Assessment) has been being developed by David Thornton of Her Majesty's Prison Service. This is an instrument that is currently being used within the national prison SOTP, and which is described in the SOTP Accreditation documentation. In brief, four 'risk domains' are considered, relating to sexual interests, distorted attitudes, socio-affective functioning, and self-management. In North America, there is Hanson's SONAR (referred to above), which again depends on clinical observation.

To carry out meaningful research into risk assessment, large numbers of subjects, good data and reliable outcome measures are needed. One problem is the dependence of such studies on reconvictions, which are known to underestimate true re-offending. Research that develops ways of overcoming this problem (for example, making use of statistics relating to arrests, probation or parole breaches, or social service information) would be welcome.

5. Treatment

Most of the questions raised by stakeholders related to treatment efficacy. Data is steadily increasing in this area, and though studies are of variable quality (as observed by White et al, 1998), reviews and meta-analyses tend to conclude that evidence of efficacy has only been demonstrated for cognitive-behavioural type programmes, and for anti-libidinal medication (usually in conjunction with a cognitive-behavioural programme). The most recent meta-analysis is in a paper submitted for publication by an American group (not yet in the public domain) that included 26 treatment studies. Similarly, there is an on-going project co-ordinated by Karl Hanson on behalf of the American Association for the Treatment of Sexual Abusers (ATSA) which is collecting data from treatment programmes and reports annually; again, cognitive behavioural programmes are emerging as most efficacious.

As noted in the introduction to this paper, the majority of studies relating to sex offender treatment are not in the form of randomised controlled double-blind trials. Ethical issues associated with randomisation, difficulties in knowing what to control for, and the impracticality of providing double blind treatments make such approaches problematic. A good attempt was made by the large SOTEP (Sex Offender Treatment Evaluation Project) study in California in which imprisoned sex offenders were randomised into control and treatment groups, with offenders receiving standard cognitive-behavioural therapy and followed up for five years (Marques et al, 1994). Unfortunately, funding stopped prior to the production of a final report, but I understand that a convincing treatment effect has not been demonstrated.

More data relating to cognitive-behavioural interventions is clearly needed, some of which should come from the prison SOTP, which is treating approximately 700 sex offenders a year within a tightly controlled programme. Interestingly, the original intention was for offenders to be randomised into SOTP, but this was blocked for political reasons. In any case, the first outcome studies should be reported in 2001.

While cognitive-behavioural programmes still need to prove themselves, the winds are at least encouraging. This is not the case for psychodynamic type approaches, which are still common in the NHS. Here, what evidence there is suggests that, if anything, psychodynamic psychotherapy may make offenders worse. Given the persistence of psychodynamic psychotherapy in the treatment of sex offenders within the Health Service, there is a clear research need to establish whether or not such an approach has anything to offer in the treatment of sex offenders. If positive data is not forthcoming, then questions will need to be asked about the continued survival of psychodynamic psychotherapy as an appropriate treatment modality for sex offenders. (Romero J.J., and Williams L.M., (1983) Borduin C., Henggeler S., Blaske D., and Stein R.(1990)).

Another issue, flagged up by the stakeholder questions, relates to the treatment of psychopathic sex offenders. Currently they are excluded from the prison SOTP as it is believed that traditional cognitive behavioural treatment results in poor outcome. The

prison service is currently developing alternative treatment approaches for this group, which will need to be carefully evaluated.

5.1 Drug Treatment

Most of the above discussion about treatment is not particular to what does, or can, take place in forensic mental health settings. What is specific to such settings is the potential to use medication, a treatment approach that is probably underused because of the lack of psychiatric input to sex offender programmes. Unlike psychotherapy, drug treatments are amenable to randomised controlled trials, and it is of interest that virtually none exists.

Until the last few years, the main types of pharmacological treatment were anti-libidinal medication - cyproterone acetate in the UK and Canada, and Depo-Provera in the United States - with evidence of their effectiveness coming primarily from open trials (reviewed by Prentky, 1997). A recent study claimed that triptorelin (a drug which blocks the secretion of gonadotropin-releasing hormone), brought about a marked reduction in sexual fantasies and sexual drive, with fewer side effects than are normally reported with cyproterone or Depo-Provera (Rosler and Witztum, 1998).

Another development has been the use of SSRIs such as fluoxetine (Prozac) in the treatment of sex offenders. Some claim that these drugs produce a selective reduction in deviant fantasy and arousal, with a reduction in offending (Kafka and Prentky, 1992; Greenberg and Bradford, 1997), although whether this is due to a direct effect on sexual behaviour or the result of reduced preoccupation and feelings of compulsion is unclear.

SSRIs are relatively safe drugs, and if they are indeed effective in the treatment of sex offenders then their use should almost certainly be more widespread than is currently the case. Where a large reduction in sexual drive is needed, triptorelin may prove a more effective and better tolerated treatment than cyproterone or Depo-Provera. Both propositions require testing, which could be done in a relatively straightforward manner.

6. Service Delivery

No questions in relation to this area were identified in the stakeholder survey. There are, however, two main developments in respect of service delivery that have occurred in the UK.

The first relates to the establishment of a system of accreditation for all offending behaviour treatment programmes offered in the probation and prison services. The intention is to ensure that these programmes are evidence-based, and are delivered in a manner that preserves treatment integrity. To be accredited, programmes must meet 11 criteria (for example, they must articulate a clear model of change; use methods that have been shown to be effective; address engagement and motivation; and include ongoing evaluation). They are also required to pass regular audit. As mentioned in the introduction to this paper, two sex offender programmes in the prison and one in the probation service have been accredited; two further probation programmes, and a number of prison programmes will be coming forward for accreditation in the next year.

Although accreditation is now part of Home Office policy, it has its critics. In particular, there is concern that the development of more innovative programmes, for which there is as yet little evidence, may be stifled. It is also argued that some treatment approaches, for example therapeutic communities, do not fit easily into the accreditation format. The effect of accreditation on service delivery, therefore, is a real issue, and one that itself should be the subject of research evaluation.

The second relevant development is the emergence of multi-agency risk panels in which the police and probation services take the lead in determining the risk of sex offenders in the community, and formulate management plans. Health providers have been involved only uncomfortably with this, partly because of concerns about confidentiality (which I believe are misplaced), and partly because of a lack of knowledge about sex offender risk and management. The Police Reducing Crime Unit in the Home Office has commissioned research into these panels. This should be published soon. However, it has not looked to any extent at the way in which forensic mental health, and indeed general psychiatric, services interact with these panels.

Another development of interest has been the formation of multi-agency, multidisciplinary sex offender assessment and treatment projects in England: best known are the Challenge Project in Kent (probation and psychology), the Thames Valley Project (probation and social services), the MAP (Multi-Agency Project) initiative in Hull (probation and social services), and our own SOTP+ and Sexual Behaviour Unit in Newcastle (forensic psychiatry and probation). Although each project is carrying out its own evaluation, there might be value in comparing process and outcome.

7. Professional Development

No questions were identified in the stakeholder survey, and I am not aware of any recent or ongoing research work related to this apart from the monitoring associated with prison SOTP training for tutors and managers. One possible line of enquiry, however, might be to identify the components that characterise successful training programmes for those wanting to work with sex offenders. There are certainly a number of courses and trainers, and a curriculum could be developed around these.

8. Three High-Priority Research Questions

In the above discussion, a number of research issues were raised which I believe are topical and of particular relevance, given the current state of knowledge about sex offending. In prioritising questions for research, however, I have focused on areas that are most relevant to forensic mental health, and which require forensic mental health expertise. To date, there has been a lack of support for mental health research that is not justified by its potential for important findings. Thus, the three questions I suggest prioritising are:

1. the efficacy of pharmacological treatments in alleviating sexual psychopathology and reducing sexual offending

In relation to this there are two treatment approaches that I suggest should be evaluated:

- the use of SSRIs
- a comparison of the antilibidinal medications cyproterone acetate and triptorelin.

2. diagnoses in sex offenders

Again there are two issues to be examined:

- whether more reliable and valid ways of diagnosing paraphilias can be developed
- the prevalence of mental illness and personality disorder among convicted sex offenders.

3. whether psychodynamic and related psychotherapies have anything to offer in the treatment of sex offenders.

9. Effective Commissioning of Research

Sex offending is a fairly specialised area, and I believe that commissioning of research will be most effective if it is targeted primarily at those with the relevant expertise. In addition to invited tenders, the other avenue into those with relevant experience is through NOTA (the National Organisation for the Treatment of Abusers), which is an active and well organised group with a large membership; the majority of those in the UK with a research interest in sex offenders are members. It has its own journal as well as a newsletter, through which opportunities can readily be advertised.

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