Summary and Conclusions

Medical and Psychological Methods for Preventing Sexual Offences Against Children

A Systematic Review

Swedish Council on Health Technology Assessment

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Summary and Conclusions of the SBU Report:

Medical and Psychological Methods for Preventing Sexual Offences Against Children

A Systematic Review

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The primary goal in treating individuals at risk of committing sexual offences against children is to prevent more children from becoming victims. Few crimes are considered to be as repugnant as sexual offences against children, and society highly values every offence that can be prevented. However, relatively little interest has been directed at research intended to identify which medical and psychological interventions that actually prevent individuals at risk and known perpetrators from committing sexual offences.

The Swedish government assigned SBU to assess the effects of methods used to treat people who have committed, or are at risk of committing, sexual offences against children. Concurrently, the Swedish National Board of Health and Welfare was assigned to survey the use of such treatments in Sweden.

This systematic literature review scrutinises the scientific evidence for preventive medical and psychological interventions directed at offenders. We identified major weaknesses in the scientific evidence, e.g. regarding the largest category of offenders; adult males. In the absence of findings from reliable research, a reasonable treatment and follow-up strategy might be to reduce sex crime-specific risk factors, e.g. sexual preoccupation, in offenders having the highest risk of recidivism.

SBU's Conclusions

- Major deficiencies were found in the evidence concerning effective medical and psychological interventions for individuals that have committed sexual offences against children. This is serious, since the purpose of this treatment is to prevent new offences. Better research is necessary – primarily controlled studies that are sufficiently large and include several countries. Such research is particularly important in light of the *Council*

of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse.

- For adults that have committed sexual offences against children, the scientific evidence is insufficient for determining which treatments that could reduce sexual reoffending. The lack of evidence concerns both benefits and risks with pharmacotherapy and psychological treatment programmes. Sufficiently large studies of high methodological quality are essential to remedy this.

- Concerning adolescents that have committed sexual offences against children, limited scientific evidence suggests that multisystemic therapy (MST) prevents recidivism. This intervention is based on a combination of systemic family therapy, social learning theory, and social ecological theory. Possible effects of other treatment methods could not be appraised.

- As regards children with sexual behavioural problems (SBP) directed at other children, the scientific evidence is insufficient to draw conclusions about if cognitive behavioural (CBT) could decrease the risk for future sexual offending. Likewise, the effects of other treatment methods could not be appraised.

- For adults and adolescents that have not committed sexual offences against children, but are at higher risk (e.g. individuals with sexual attraction to children), there is a lack of research on possible effects of preventive methods. Hence, it is important to develop effective interventions.

SBU's Summary

Background and aim

In 2007, Sweden had 2 014 reported cases of suspected sexual coercion, attempted rape, or rape of children under 15 years of age. An additional 1 530 cases categorised as other sexual offences were reported. Swedish surveys indicate that 7 to 14 percent of girls and 3 to 6 percent of boys report forced intercourse before 18 years of age. Only about 10 percent of all sex crimes are reported to the authorities, and this figure might be even lower when the victims are children.

Most child victims of sexual abuse are molested by someone close to them, often a friend or close relative. The perpetrators of sexual offences against children are usually adult or adolescent men, and many have, or have had, concurrent sexual relations with adults. Offenders' risk factor profiles, motives, and treatment needs vary. Many have grown up under adverse conditions and may exhibit sexual behaviour problems already at a young age. Most offenders do not have a criminal record, and very few have been convicted of sex crimes previously. The primary aim of this report is to assess the effects of preventive methods aimed at either identified perpetrators of sexual offences against children or at people who are at risk of committing sexual offences against children.

The Swedish Prison and Probation Service currently offers a manual-based treatment programme to prevent recidivism among sex offenders. Treatment is based on the principles of cognitive behavioural therapy (CBT) and focuses on problems in relationships and cohabitation. It aims at lowering the impact of risk factors driving sexual offences, e.g. by changing frequently distorted views towards sexuality and reducing sexual preoccupation and easily triggered aggressiveness. The Swedish Prison and Probation Service seldom uses testosterone-inhibiting drugs in sex offender treatment, they are more common in forensic psychiatry.

This report aims to investigate the scientific evidence addressing the following questions:

- How effective are treatment methods targeting adults and adolescents who have committed sexual offences against children in preventing sexual reoffending?
- How effective are preventive methods targeting adults and adolescents at risk of committing sexual offences against children?
- How effective are treatment methods targeting children with sexual behaviour problems (SBP) in preventing future sexual offending?
- What ethical and social aspects are associated with methods used to prevent sexual offences against children?
- Are treatment or preventive methods cost effective?

Methods

This systematic literature review complies with SBU's meticulous methodology. We search several scientific literature databases for published studies relevant to the research questions. The project group then uses predetermined quality criteria to select the studies to be included in the assessment. Every study used in formulating SBU's conclusions has been appraised for quality, and specially designed tables are used to present core information.

The review includes an appraisal of the relevance and methodological quality of the studies – study design, internal validity (reasonable protection against systematic error), analysis of results, statistical power, and generalisability. SBU grades the findings on the strength of the scientific evidence (Facts 1).

Facts 1 Study quality and strenght of the evidence.

Study quality refers to the scientific quality of an individual study and its capacity to answer a specific question in a reliable way.

Evidence grade refers to the appraised strength of the collective body of scientific evidence and its capacity to answer a specific question in a reliable way. SBU uses an international evidence grading system called GRADE. Study design is the primary factor considered in the overall appraisal of each outcome measure. Secondary factors that can increase or decrease the strength of the evidence include: risk of bias, inconsistency, indirectness, effect size, data precision, risk of publication bias, and other aspects, e.g. the dose-response relationship.

Evidence grades – four levels

Strong scientific evidence (⊕⊕⊕⊕)
Based on high or medium quality studies with no factors that weaken the overall assessment.

Moderately strong scientific evidence (⊕⊕⊕○)
Based on high or medium quality studies with isolated factors that weaken the overall assessment.

Limited scientific evidence (⊕⊕○○)
Based on high or medium quality studies containing factors that weaken the overall assessment.

Insufficient scientific evidence (⊕○○○)
Scientific evidence is deemed insufficient when scientific findings are absent, the quality of available studies is low, or studies of similar quality present conflicting findings.

The stronger the evidence, the lower the likelihood that new research findings would affect the documented results within the foreseeable future.

Conclusions
SBU's conclusions present an overall assessment of benefits, risks, and cost effectiveness.

Evidence-graded results

Interventions for adults who have committed, or are at risk of committing, sexual offences against children

- The scientific evidence is insufficient to determine if cognitive behavioural therapy (CBT) with relapse prevention is effective at reducing sexual reoffending among adult child molesters (⊕○○○).

- No scientific evidence is available to determine if psychological interventions other than CBT or pharmacological treatment reduce sexual reoffending among adult child molesters (lack of studies).

- No scientific evidence is available to determine if either psychological or pharmacological treatment modalities can prevent sexual offending among adults who have not sexually abused a child, but are at risk of doing so (lack of studies).

Interventions for adolescents who have committed, or are at risk of committing, sexual offences against children

- Limited scientific evidence suggests that multisystemic therapy (MST), a community-based programme based on systemic family theory and social learning theory, may be effective in preventing sexual reoffending among medium-risk adolescent sex offenders (⊕⊕○○).

- The scientific evidence is insufficient to determine if cognitive behavioural therapy is effective at preventing sexual reoffending among medium-risk adolescent sex offenders (⊕○○○).

- No scientific evidence is available to determine the effect of CBT on sexual reoffending among adolescent sex offenders with low or high recidivism risk (lack of studies).

- No scientific evidence is available to determine the effectiveness of other methods (psychological or pharmacological) aimed at preventing sexual reoffending in adolescent sex offenders (lack of studies).

- There is no scientific evidence to determine the effectiveness of methods aimed at preventing sexual offending in at-risk adolescents who have not sexually abused a child, but are at risk of doing so (lack of studies).

Interventions for children with sexual behaviour problems

- The scientific evidence is insufficient to determine if cognitive behavioural therapy (CBT) combined with parental support is more effective than standard treatment in preventing sexual offending among children with sexual behaviour problems (SBP) (⊕○○○).

- No scientific evidence is available to determine the effectiveness of other preventive interventions aimed at children with sexual behaviour problems (lack of studies).

Health economics

- The scientific evidence is insufficient to determine the cost effectiveness or socioeconomic consequences of psychological or pharmacological treatment of adult child molesters (⊕○○○).

- The evidence is insufficient regarding health economic studies on treating adolescent sex offenders or children with sexual behaviour problems (SBP). This also applies to people that have not committed, but are at risk of committing, sexual offences against children (lack of studies).

Table 1 *Summary of findings regarding offender-oriented interventions aimed at reducing sexual offending against children.*

Outcome	No. participants (no. studies & study design)	Results (95% CI)
Effects of cognitive behavioural therapy (CBT) with or without relapse prevention among adult sex offenders against children.		
Sexual reoffence (medium risk offenders, 5 years follow-up)	484 (1 RCT)	RR 1.10 (0.78; 1.56)
Sexual reoffence (lower-risk offenders, 3–5 years follow-up)	362 (3 OBS)	RR 0.23 (0.03; 2.01) RR 0.09 (0.01; 0.74) RR 1.03 (0.15; 6.92)
Sexual reoffence (higher-risk offenders, 5 years follow-up)	114 (1 OBS)	RR 0.44 (0.19; 0.98)
Effects of multisystemic therapy (MST) and cognitive behavioural therapy (CBT) in adolescents that have committed sexual offences against children.		
Sexual reoffence (9 years follow-up)	48 (1 RCT)	RR 0.18 (0.04; 0.73)
Sexual reoffence (16 years follow-up)	148 (1 OBS)	RR 0.41 (0.16; 1.03)
Effects of cognitive behavioural therapy (CBT) in children with sexual behavioural problems (SBP) targeted against other children.		
Sexual reoffence (10 years follow-up)	135 (1 RCT)	RR 0.16 (0.02; 1.25)

CI = confidence interval; RR = relative risk; RCT = randomised controlled trial; OBS = observational study

	Event rate in control group	Quality of evidence
	20%	⊕○○○
	5% 16% 5%	⊕○○○
	28%	⊕○○○
	46%	⊕⊕○○
	21%	⊕○○○
	10%	⊕○○○

Table 2 *Summary of the evidence regarding offender-oriented interventions aimed at reducing sexual offending against children. The table specifies the basis for rating the evidence. A zero indicates no reason to criticize this point. A minus sign indicates that the issue was indeterminable. A minus sign and question mark indicate*

Outcome	No. participants (no. studies)	Study type	Risk of bias
Effects of cognitive behavioural therapy (CBT) with or without relapse prevention among adult sex offenders against children.			
Sexual reoffence (medium risk offenders, 5 years follow-up)	484 (1)	RCT ⊕⊕⊕⊕	0
Sexual reoffence (lower-risk offenders, 3–5 years follow-up)	362 (3)	OBS ⊕⊕○○	–1
Sexual reoffence (higher-risk offenders, 5 years follow-up)	114 (1)	⊕⊕○○	–1
Effects of multisystemic therapy (MST) and cognitive behavioural therapy (CBT) among adolescents that have committed sexual offences against children.			
Sexual reoffence (9 years follow-up)	48 (1)	RCT ⊕⊕⊕⊕	0
Sexual reoffence (16 years follow-up)	148 (1)	OBS ⊕⊕○○	–1
Effects of cognitive behavioural therapy (CBT) in children with sexual behaviour problems (SBP) targeted against other children.			
Sexual reoffence (10 years follow-up)	135 (1)	RCT ⊕⊕⊕⊕	0

RCT = randomised controlled trial; OBS = observational study

some deficiencies, but these are not important enough to lower the evidence grade. Minus 1 or 2 indicate deficiencies that lower the quality of the evidence. It is not possible to achieve an overall evidence grade above ⊕⊕⊕⊕ (strong scientific evidence) or below ⊕○○○ (insufficient scientific evidence).

Incon-sistency	Indir-ectness	Impre-cision	Publica-tion bias	Effect size	Quality of Evidence
–	–1	–2	0	0	⊕○○○
0	0	–1	0	0	⊕○○○
–	–1	–1	0	0	⊕○○○
–	–1	–1	–?	0	⊕⊕○○
–	–1	–1	0	0	⊕○○○
–	–1	–2	0	0	⊕○○○

Concluding discussion

Persons who have committed, or are at risk of committing, sexual offences against children

Sexual offences against children – a difficult-to-research topic

Despite severe consequences for victims and society, we found remarkably little research of acceptable quality and methodology that addressed prevention of sexual offences against children. It is difficult to conduct research on the effects of crime prevention initiatives. The ideal study design is the randomised controlled trial (RCT), where offenders or people at higher risk of becoming offenders are randomly assigned to either a treatment group (i.e. the studied intervention) or a control group (e.g. another intervention or no treatment). The advantage of this study design is that all potential differences between the groups at the outset of the study should depend on chance alone; and if the groups are sufficiently large we can assume that they are more or less identical. Hence, we can be relatively certain that an observed difference in outcome between the two groups is due to the intervention and no pre-existing differences. This study design is seldom used in crime prevention research, mainly because of practical and ethical reasons. Instead, observational studies are conducted. In observational studies, the offenders or those at higher risk are assigned to treatment and control groups by other means than by randomisation. If the distribution is based on, e.g. the treatment motivation of the participants, an imbalance arises between the groups. This could contribute to an observed difference in the recidivism risk between the groups. Consequently, we cannot be certain that a difference in reoffending is a result of the treatment. Using statistical methods – assuming we have sufficiently detailed information about the offenders in the study – we can adjust for possible baseline differences between the groups. But since the differences between the groups cannot be attributed to chance,

we can never be completely certain that the results are not due to some unmeasured, and perhaps unknown, risk factor that is more common in one of the groups.

Adults that commit sexual offences against children

Adult men account for over 70 percent of all sexual abuse against children reported to the police or that leads to prosecution. Only one randomised controlled trial investigated the effects of treatment on sexual reoffending by adult perpetrators of sexual offences against children. Treatment involved psychotherapy and was based on cognitive behavioural therapy (CBT) and relapse prevention. The study could not verify any effect from treatment. This finding should not, however, be interpreted as evidence that the method is without effects. Although this study is by far the largest of those included in our review, it was too small to statistically secure any potential effect of treatment. And since the sex offenders in the study were found to be at medium risk of reoffending, we cannot rule out the possibility that the method has effects on preventing recidivism in offenders at higher risk of relapse. It is also possible that variations of CBT, other than those studied in the trial, might have preventive effects. In addition to the randomised trial, four observational studies were included in the scientific evidence on treating adult offenders. Concurrently, the effects of different variations of CBT were addressed. However, these studies had deficiencies that rule out the potential for drawing reliable conclusions about treatment effects. No studies of sufficient quality addressed other psychological or pharmacological interventions.

It is relatively uncommon for adult females to commit sexual offences against children, although it does happen. No studies addressed the effect of treatment of females who sexually offend against children.

In this field, it is seldom acknowledged that psychotherapeutic interventions, like pharmaceuticals, might have serious side

effects. Under certain circumstances, in some subjects and with certain interventions, those who receive treatment might have a higher risk of sexual reoffending than those who are not treated. For instance, prolonged or intense interventions for offenders with low relapse risk or motivation, or grouping low-risk offenders with those at high risk for recidivism, could result in negative and undesirable outcomes.

Adolescents that commit sexual offences against children

Adolescents commit 20 to 30 percent of all reported cases of sexual abuse against children. Adolescent perpetrators of sexual offences often have other problems, such as adaptation problems in school, other criminality, and substance misuse. Despite the elevated risk, sexually abusive behaviour in adolescents seldom continues into adulthood. The scientific evidence on the potential effects of treatment are somewhat better for adolescents that commit sexual offences against children than for their adult counterparts. The evidence includes a randomised controlled trial and an observational study of acceptable quality. The randomised trial investigated the effects of multisystemic therapy (MST), a community-based programme based on social learning, and social ecological theory and using systematic family therapy. The observational study used CBT and structured family therapy as its main components. Deficiencies in the observational study did not enable conclusions to be drawn. Although the randomised trial was small, it provides limited scientific evidence that MST can be used to reduce sexual reoffending among adolescents that have sexually abused children.

Although more research is necessary to identify the most effective treatment methods, it is probable that early intervention in young sex offenders contributes towards reducing the number of future victims. Nevertheless, psychological interventions carry a risk for side effects, which is especially important to consider when treating young people. For instance, some data suggest that group

therapy, particularly in an institutional setting, might increase the risk of recidivism in young offenders.

Children with sexual behaviour problems directed at other children

Sometimes, it can be difficult to determine exactly where to draw the line between a child's natural sexual curiosity and sexual abuse. At certain ages, transient, unassertive touching of body parts, including genitalia and breasts, and interest in sexuality and sexual play could often be perceived as normal. However, such behaviour must not harm – emotionally or physically – the children involved. Children exhibiting exaggerated, sexualised behaviour towards others should raise concern, particularly if this is combined with aggressive behaviour. In some cases, these sexual behaviour problems continue into adolescence and adulthood, and might be expressed in sexual abuse of children or adults. Because of this, and the repudiation of children with such sexual behaviour problems (SBP) against other children, it is essential to develop effective developmentally adapted therapies for these children. Children that act out sexually might have been subjected to psychological, physical, or sexual abuse themselves, or live in socially vulnerable environments with inadequate adult support. It might be that these children have developmental disabilities or neuropsychiatric functional impairments. If so, special initiatives could be needed to investigate and address possible underlying or contributing problems.

Only one randomised controlled trial addressed the effects of treatment in children with SBP. This trial randomised the children to either cognitive behaviour therapy or group play therapy. Play therapy is an example of psychological treatments that is offered to children in Sweden. Also, both interventions were combined with parental support programmes. After treatment, the children were monitored for reported sexual offences during a 10-year period. Of the children treated with play therapy, 10 percent

committed a sexual offence during follow-up compared to only 2 percent among those receiving CBT. The study was well executed, but too small, and the results not statistically significant. Hence, our findings suggest that the scientific evidence is insufficient to determine if CBT is effective in preventing future sexual offences in children with SBP.

It should be noted that a child's sexual behaviour might be misinterpreted as more threatening than it actually is. Hence, reactions from others might be exaggerated. If a child is viewed as a future sex offender, this could lead to unjustified stigmatisation that might negatively affect the child's development. Hence, this risk must be balanced against the risk for sexual abuse of others by children with SBP. If children with SBP are subjected to excessively intense or inappropriate therapy, this in itself could increase the risk for future antisocial behaviour. This is important to consider, since the long-term risk for sexually abusive behaviour in untreated children with SBP is low.

Persons at higher risk of committing sexual offences against children

Part of our assignment was to assess the effects of methods aimed at individuals at higher risk of committing sexual offences against children, but who had not committed any such offence. Some people with a sexual interest in children might have sufficient protective factors that prevent them from actually committing an offence. However, certain circumstances might increase their risk of "crossing the line". This category includes individuals who have recurrent sexual fantasies about children (e.g. paedophilia) or who watch child pornography. Many suffer from their situation, and they often have concurrent mental illness and an elevated risk of suicide. The difficulty in seeking help from health and social services is apparent, given fears for condemnation and stigmatisation.

In Great Britain and Germany, among other nations, telephone-based helplines have been organised. People at risk of committing sexual offences against children can call into these anonymously and receive counselling and referral to appropriate treatment services. Substantial experience with these helplines indicates that it is possible to reach people at risk and motivate them to seek preventive treatment. Anonymity can be critical in making the initial contact, and individuals may need time to build up their motivation to receive treatment. Sweden currently has no programmes aimed at reaching self-identified individuals at risk of child sexual abuse.

Unfortunately, no studies have assessed the effects of treating high-risk individuals who have not sexually offended against children. Since we cannot say which methods that successfully prevent offences against children, the question is: How can we manage help-seeking individuals at risk? More research is necessary. In the absence of specific guidelines for treating individuals at risk, the most ethically defensible position would be to assess the presence of treatable risk factors for child sexual offences including concurrent psychiatric disorder, and offer individualised treatment.

Treatment methods

Psychological treatment methods

Multisystemic therapy (MST), a community-based programme using systematic family therapy, and based on social learning, and social ecological theory, reduces the risk of recidivism in adolescents that have committed sexual offences against children. For adult perpetrators of sexual offences against children, we did not find sufficient scientific evidence that psychotherapeutic methods reduce the risk of recidivism. Unfortunately, treatment methods that caregivers *perceive* to be effective cannot be assessed objectively in the absence of controlled, preferably randomised, studies.

Some studies even suggest that adult offenders that received psychological treatment might recidivate in sexual offending more often than those who were administered standard care. Although this information is based partly on low-quality studies, it is reason for concern and should be taken seriously. Given this background, one could ask the question of whether treatment should even be offered.

Research on sex offenders in general (i.e. not only those that sexually abuse children) suggests that treatment is more successful if responsivity adheres – to the risk-needs-responsivity (RNR) principles for effective offender treatment. No specific research currently affirms that these principles also apply to perpetrators of sexual offences against children. However, despite the lack of scientific consensus, it is perceived to be unethical to deny treatment – thereby reflecting a fundamental dilemma in this field. Hence, we suggest that in the absence of better research on this group of offenders, treatment should be based on the RNR principles, and the effects should be documented. According to the principles, offenders having high or moderate risk of recidivism should be prioritised for treatment and offered longer and more intensive interventions. Offenders having *low* recidivism risk should receive shorter, less-intensive interventions and should not be grouped with offenders having higher recidivism risk. Moreover, treatment should target casual risk factors driving sex crimes, adhere to the principles of social learning theory, and be adapted to the learning style of the individual.

Pharmacotherapy

Treatment with testosterone-inhibiting drugs is often advocated to inhibit the sex drive of individuals convicted of, or at risk of committing, sexual offences. Such treatment can be delivered in tablet form, or by long-acting injection, and is occasionally referred to as chemical castration. The effects of testosterone-inhibiting drugs are temporary, cease if treatment is discontinued, and can be ended quickly and completely with administration of male sex

hormone, e.g. with doping agents such as anabolic-androgenic steroids. No scientific evidence to date support that testosterone-inhibiting drugs play a decisive role in reducing recidivism in sexual offences against children. We are not always aware of the specific underlying motives for sexually abusive behaviour towards children. Several different driving factors may be present concurrently, and if offences stem mainly from compulsive, highly aggressive, or other non-sexual motives, then treatment might have no effect.

Clinical experience shows that many people who were treated with testosterone-inhibiting drugs for excessive sex drive experienced reduced sexual preoccupation and greater well-being. By reducing hypersexuality or sexual preoccupation, pharmacotherapy can make it easier for the treated person to participate in psychological treatment. However, the side effects of testosterone-inhibiting treatment can be serious, particularly in long-term treatment. Lowered levels of male sex hormone could lead to osteoporosis and increased risk of fracture, and also increase the risk of cardiovascular disease. Weight gain, including the risk of diabetes, enlargement of mammary glands, and liver changes are other possible side effects. Some individuals can acquire symptoms of depression. It is essential that people receiving testosterone-inhibiting treatment understand the importance of having thorough check-ups to reduce the risk of adverse effects. Given the potential risks of long-term treatment, the benefits of treatment must be weighed against infringements of personal integrity and the risk of medical complications.

In young offenders and children with SBP, testosterone-inhibiting treatment is ruled out for medical and ethical reasons. Also, there is no evidence to recommend such treatment in women for the purpose of reducing the number of sexual reoffences.

Ethical and social aspects

Professionalism in care

Few crimes are perceived detestable as sexual offences against children. In Western nations, public debate often centres on how to punish the perpetrator. The primary aim in treating people who have committed, or are at risk of committing, sexual offences against children is to prevent more children from becoming victims. Hence, it is essential for society to pay greater attention to evidence-based prevention of new sexual offences against children.

Constructive attempts towards rehabilitation require a professional approach. It is important to increase awareness in social and health care services about attitudes and routines that could inhibit help-seeking behaviour and contribute to stigmatisation and isolation. For people seeking help for their fear of committing sexual offences against children, any initial condemnation and unprofessional interaction might make them hesitant to seek help from health-care or social services in the future. To achieve optimum effects from treatment, a working treatment alliance based on respect for the offender as a person between the sexual offender and the care-giver is necessary. In other words, professional caregivers must always try to distinguish between the action; unacceptable sexual abuse, and the person seeking help.

Equality in care

The Swedish Prison and Probation Service offers a specialised treatment programme for convicted sex offenders. The programme is similar to international programmes for sexual offenders and based on structured and manualbased CBT, social skills training, and relapse prevention. Prerequisites for participating in this programme are that: the convicted offender must speak Swedish (occasionally English is acceptable), possess sufficient intellectual or cognitive capability, and benefit from treatment. The length of

the prison sentence is also important, and offenders with short sentences could miss out on treatment if it cannot be completed prior to their release. The same applies to those who have committed less serious sexual offences and have been sentenced to probation or fines instead of incarceration – not all probation services across the country have the expertise to treat perpetrators of sexual offences against children. Geographic distance can also create an obstacle against receiving specialised treatment. Hence, convicted sex offenders in the Swedish Prison and Probation Service might go without treatment because of logistical and practical barriers. A potential consequence of unequal access to care is that some individuals at higher risk of sexual reoffending will not receive treatment.

Health economic aspects

We found only three studies that addressed the health economic aspects of treating people convicted of sexual offences against children. These studies have major deficiencies, and the findings cannot be applied in a Swedish context. No studies in health economics were of sufficient quality to address the treatment of identified perpetrators of sexual offences against children, or people at risk for this.

Other types of economic studies show, however, that society highly values every prevented sexual offence against children. Given this, and the fact that the costs of implementing treatment programmes are relatively low, it is very likely that future treatment programmes will be considered *cost-effective* if they can effectively prevent sexual offences.

Uncertainties and the need for research

There is a need for well-designed and -executed studies that assess the preventive effects of treatment in adults who have committed sexual offences against children. To be able to evaluate the effects of treatment, large, multinational, randomised controlled trials must be conducted. Sweden should participate – both to develop national expertise and to factor in the circumstances specific to Sweden. Sweden is probably too small to conduct national treatment studies, within Sweden, that would have adequate statistical power.

High quality studies that assess the effect of psychological treatment for children with SBP are necessary to improve the poor evidence currently available. The same applies to adolescents that have committed sexual offences against children, even if the information base is somewhat better for this age group.

The evidence is insufficient to describe the preventive effects of interventions in people at risk of committing sexual offences against children. Importantly, although no studies have investigated effects on outcomes, some studies suggest that these people can be reached through various types of potentially effective interventions.

In addition to using criminal recidvism as the major outcome measure, future studies should also measure changes in relevant risk factors during the course of treatment. This can enhance statistical power and shorten follow-up periods. Furthermore, it could provide information on the specific mechanisms that contribute to an observed effect.

Few health economic studies are available on this topic. Studies need to address the costs and effects of treating individuals that have committed, or are at risk of committing, sexual offences against children.

Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse

The Council of Europe has adopted a convention aimed at protecting children against sexual exploitation and sexual abuse. Sweden has signed the convention and is currently investigating the question of whether we should join. If we join the convention it would mean assuming an obligation to offer *effective* treatment to perpetrators of sexual offences against children, individuals at higher risk of committing such offences, and to children with SBP. Further, the convention implies that we have to *assess the effects* of initiated programmes. The countries that join the convention, therefore, should share a common interest in developing effective methods to prevent sexual offences against children. We suggest that these countries initiate collaborative research to bridge the major knowledge gaps in this field.

Reports published by SBU

SBU Reports in English (2001-2010)

Treatment of Hemophilia A and B and von Willebrand Disease (2011), no 208E
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SBU Evaluates Health Care Technology

Below is a brief summary of the mission assigned to SBU by the Swedish Government:

- SBU shall assess healthcare methods by systematically and critically reviewing the underlying scientific evidence.
- SBU shall assess new methods as well as those that are already part of established clinical practice.
- SBU's assessments shall include medical, ethical, social and economic aspects, as well as a description of the potential impact of disseminating the assessed health technologies in clinical practice.
- SBU shall compile, present and disseminate its assessment results such that all parties concerned have the opportunity to take part of them.
- SBU shall conduct informational and educational efforts to promote the application of its assessments to the rational use of available resources in clinical practice, including dental care.
- SBU shall contribute to the development of international co-operation in the field of health technology assessment and serve as a national knowledge centre for the assessment of health technologies.

Medical and Psychological Methods for Preventing Sexual Offences Against Children

The report on Medical and Psychological Methods for Preventing Sexual Offences Against Children from the Swedish Council on Health Technology Assessment (SBU) is a systematic review of the scientific literature in the field.

This document presents the summary and conclusions of the full report approved by SBU's Board and Scientific Advisory Committee.

The full report is available at www.sbu.se

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