WWP EN

Mapping of current practice and treatment approaches of perpetrators of sexualised violence against minors

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Year of publication: 2024
Suggested Citation: Rossoni, I., Vall, B. & Pauncz, A. (2024). Mapping of current practice and treatment approaches of perpetrators of sexualised violence against minors. Berlin: WWP EN [European Network for the Work with Perpetrators of Domestic Violence].

Funded by the European Union

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Contents

Definitions

"Work", "model" and "program": Specific work with adult male and/or female perpetrators of child sexual abuse" or with "minors who have committed child sexual abuse". If something else is meant, this will be explicitly defined. The terms "participant" and "client" mean both participants of group work and clients of face to face work.

Primary prevention: is aimed at the general population and seeks to address risk factors for crime.

Secondary prevention: engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime.

Tertiary prevention: deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences.

Quarternary prevention: deals with the long-term, non-stigmatizing support of offenders and their effective community re-integration as full citizens

Child sexual abuse: sexual abuse and sexual exploitation of children can take multiple forms and can occur both online (e.g. forcing a child to engage in sexual activities via live streaming or exchanging child sexual abuse material online) and offline (e.g. engaging in sexual activities with a child or causing a child to participate in child prostitution). When the abuse is also recorded and shared online, the harm is perpetuated (EU Strategy for a more effective fight against child sexual abuse, 2020).

Victim/survivor: person who received/suffered the abusive / violent behaviour. This term is used as in many countries the term "victim" is more common and comprehensive but, at the same time, it is important to emphasise the term "survivor" which reflects the empowering aspect of the experience of surviving violence.

Acronyms

CBT: Cognitive Behavioural Therapy
CEP: Confederation of European Probation
CSA: child sexual abuse
JRC: Joint Research Centre
SAA: Sex Addicts Anonymous
WWP: European Network for the Work with Perpetrators of Domestic Violence

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Introduction

Fighting child sexual abuse (hereafter CSA) is a top priority for the European Union (EU). The EU Strategy for a more effective fight against child sexual abuse 2020-2025 outlines key measures to contrast CSA, which include the consolidation of a more robust legal and policy framework, more effective prevention measures, collaboration with industry, multi-stakeholder cooperation and more[1]. The EU's renewed commitment to fighting CSA stems from the alarming realization that the phenomenon is on the rise with perpetrators leveraging the opportunities offered by technology to reach more victims and commit crime. The COVID-19 Pandemic played a pivotal role in this, contributing to the increased isolation of children and the enhanced use of technological tools by perpetrators[2].

The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) calls for preventive and intervention programmes for perpetrators in the framework of a comprehensive strategy to prevent violence against women and girls. It obliges parties to the Convention to set up and support programmes for perpetrators, where the primary focus must be to ensure the safety and support of victims[3]. Art. 16(2) of the Convention makes explicit reference to perpetrators of sexual violence and emphasizes the need for States to put in place legislative and other measures to ensure access to treatment programmes to prevent re-offending. This is echoed in the Lanzarote Convention[4], which at Art. 7 calls for preventive programmes for individuals at risk of committing child sexual exploitation and abuse; and in the EU Strategy for a more effective fight against child sexual abuse 2020-2025. The latter underscores the importance of prevention programmes targeted at (potential) perpetrators of CSA, whilst also cautioning about the numerous implementation difficulties stemming from the lack of rigorous programme evaluations, the fragmentation of initiatives and limited communication and coordination between stakeholders.

Systematic data on programmes for perpetrators of sexualized violence in Europe is not readily available. There are numerous factors affecting treatment options for this target group, which relate to a country's socio-cultural context, the legal and judicial system and more generally, funding and expertise in the area[5]. Regardless, knowledge of existing programmes can contribute to painting a more accurate picture of the breadth and depth of prevention efforts and allows for a certain degree of transparency and accountability in the field of perpetrator treatment.

This paper contributes to bolstering knowledge of programmes for perpetrators of sexualized violence in the European Region with a particular focus on programmes targeting perpetrators

[1] European Commission. (2020). COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS. EU strategy for a more effective fight against child sexual abuse. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52020DC0607

[2] Ibid.

[3] Council of Europe. (2011a). *Council of Europe Convention on preventing and combating violence against women and domestic violence*. CoE. Available at https://rm.coe.int/168008482e

[4] Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, Lanzarote, 25.X.2007, Council of Europe Treaty Series No.201 (2008)

[5] Frenken, J. (1999). Sexual Offender Treatment in Europe: An Impression of Cross-Cultural Differences. *Sexual Abuse*, *11*(1), 87–93. https://doi.org/10.1177/107906329901100107

of CSA. The intent is that of mapping current practice and treatment approaches to work with this target group, identify commonalities and trends across countries and programmes, and highlight promising initiatives, whilst concurrently pinpointing gaps and areas of concern which ought to be addressed. Overall, this paper seeks to increase understanding of Europe-wide initiatives geared towards preventing sexual offending against minors.

Methodology

In order to gather information about programmes for perpetrators of sexualized violence against minors in Europe two main tools and strategies were employed: a) a literature review comprising relevant publications discussing perpetrators programmes in this area; b) two questionnaires intended to complement and expand upon the findings of the literature. The research was carried out throughout 2023 with the literature review preceding the development and dissemination of the questionnaires.

Literature review

The literature review was conducted on two different databases, Pubmed and Web of Science, utilizing 4 different keyword combinations: 'child sexual abuse perpetrator programmes'; 'child sexual abuse perpetrator interventions'; 'child sexual abuse offender programmes'; 'child sexual abuse offender interventions'. The search covered 5 years from 2018 to 2023 and was restricted to countries in the European Region (see Annex 1 for further information on countries included in the sample). Publications in the languages spoken by the lead researcher – namely English, Italian, Russian and Spanish – were included in the analysis. As seen in Figure 1, the initial search yielded a grand total of 699 results. After eliminating duplicates, the number of sources amounted to 505. These records were screened by reading the abstract, following which a total of 82 full-text articles were assessed for eligibility. 37 studies met the criteria for inclusion. An additional two studies, one of which falling under grey literature, came to the attention of the author via interaction with the Joint Research Centre (JRC) of the European Commission and were included in the review. All studies included in the analysis were categorised based on focus, definition of CSA when available, target groups, geographical scope, methodology, sample and main conclusions. A separate document was created summarising the main information related to the programmes presented in the literature (see Annex 3). This document contains information on the name of the programme, country and funding, description, level of prevention, target population, and key features. The information in this document was supplemented with data extracted from the website of the Lucy Faithfull Foundation, a British NGO working in the field of child sexual abuse. The Foundation hosts a public online database of CSA programmes in the European region which are classified based on criteria such as level of prevention, target groups and country. All relevant programmes featured on the Lucy Faithfull Foundation website were included in the analysis.

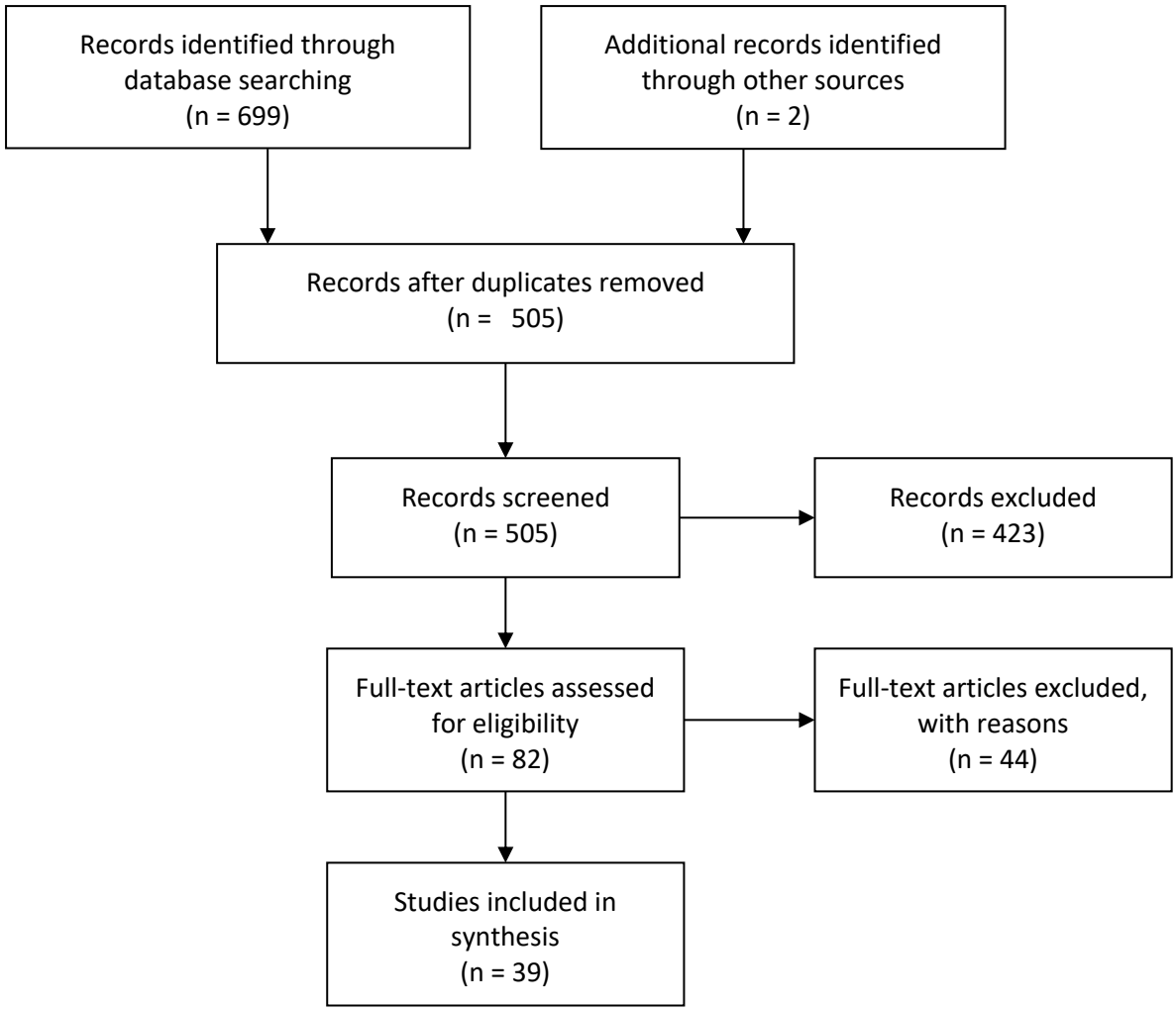


Figure 1 - Search strategy and publications retrieved

Questionnaire

Two questionnaires were created and circulated among the European Network for the Work With Perpetrators of Domestic Violence (WWP EN) members, the Confederation of European Probation (CEP) members, and other groups of experts on child sexual abuse. Both questionnaires were based on the IMPACT outcome monitoring toolkit. The first questionnaire was CSA-specific and sought to investigate organisational practices in relation to primary, secondary and tertiary prevention programmes for perpetrators. The second questionnaire, which was created for a separate project, partly overlapping with this mapping, explored work with perpetrators of various forms of violence, including gender-based violence, sexual violence, child sexual offending and violent crimes. The structure of the two questionnaires was analogous to allow for the integration of results. The questionnaires were created via Kobotoolbox and disseminated over a period of 5 months. Both questionnaires comprise a general section dedicated to demographic data on respondents and information concerning general practices, followed by ad-hoc sections on primary, secondary and tertiary prevention work. Each section delves deeper into the methodological and practical aspects of work with this target group with an eye to better understanding the profiles of service users, the type of professionals involved, treatment and therapeutic models employed, victim contact and practices surrounding programme evaluation. Answers related to work with perpetrators of other crimes are analyzed elsewhere.

Findings

Literature review

The literature review led to the identification of 39 studies on topics connected with programmes for perpetrators of child sexual abuse and exploitation. Publications covered various countries in Europe with the most widely represented being the UK (n=14; 36%) and Germany (n=9; 23%), followed Europe more broadly (n=7; 18%).

In terms of methodology, desk research was prevalent (n=15; 38%) with authors employing more or less structured approaches (systematic reviews, evidence gaps maps, less rigorous reviews), followed by studies relying on qualitative data (n=8; 21%) and articles drawing on quantitative data (n=8; 21%). Additionally, there were more theoretical pieces (n=3; 8%) and pieces centred on case studies (n=2; 5%). 1 study (3%) was mixed methods and 1 study (3%) was a project report. 1 clinical trial (3%) was also included as it revolved around the testing of a web-based application. In terms of levels of prevention, most studies focused on tertiary prevention only (n=15; 38%), followed by studies looking at secondary prevention (n=11; 28 %), research spanning the 3 levels of prevention (n=7; 18%) or 2 levels of preventions (n=5; 13%). Finally, there was one publication about primary prevention initiatives (n=1; 3%). Of the studies looking at 2 prevention levels, 2 were on primary and secondary prevention (40%) and 3 on secondary and tertiary prevention (60%).

Figure 2: Top countries represented in the literature review

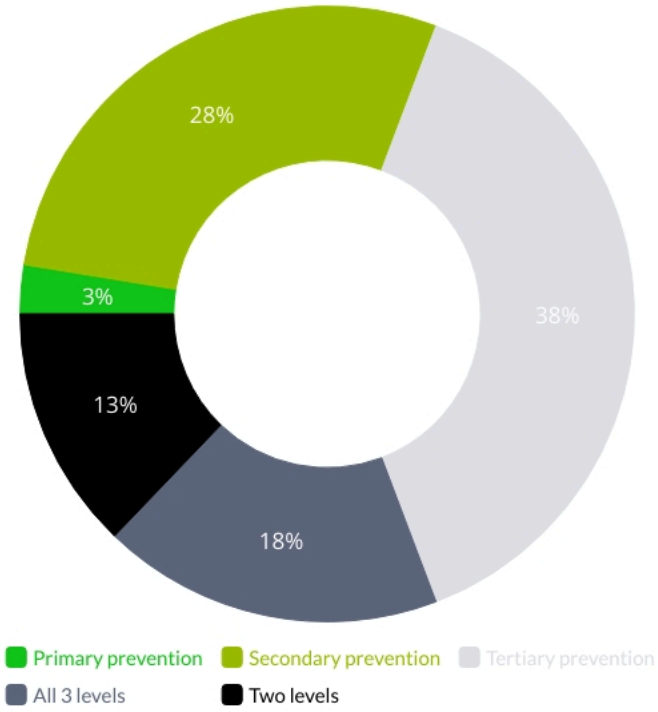


Figure 3: Level of prevention addressed by literature

The target populations of the studies included adults at risk of committing child sexual abuse (n=8; 21%), adults who have committed child sexual abuse (n=8; 21%), juveniles who have sexually offended (n=5; 13%), and multiple target groups (n=15; 38%). The latter generally applied to studies covering the 3 levels of prevention. 3 studies (8%) looked at programmes/initiatives addressed to youth, caregivers and religious officials respectively. It is interesting to note that the studies focusing on individuals at risk of committing CSA often relied on a range of terminology (e.g. non-offending minor-attracted people; non-offending individuals with paedophilia; minor-attracted persons; patients with paraphilic disorders; individuals at risk of CSA) to describe this target group. More generally, the pool of individuals targeted by secondary prevention initiatives was extremely diverse and included those who have never acted on their desires, people who may have already committed CSA but have not come to the attention of the authorities, individuals under investigation for CSA, or people charged with CSA. Numerous studies restricted their analysis to those with a sexual interest in children, yet it should be noted that research on typologies has demonstrated that individuals who commit CSA can be considered as either 'fixated' or 'regressed' offenders. 'Fixated' offenders are individuals who have never developed an attraction toward age-appropriate partners and therefore manifest a compulsive attraction toward children; whereas in the case of 'regressed' offenders, sexual offending against children is not exclusively motivated by sexual needs, rather it represents a departure from their attraction toward adults[6]. Since this research targets only a portion of the child sexual abuser population, the conclusions reached cannot be generalizable.

[6] Lim, Y. Y., Wahab, S., Kumar, J., Ibrahim, F., & Kamaluddin, M. R. (2021). Typologies and Psychological Profiles of Child Sexual Abusers: An Extensive Review. *Children (Basel)*, *8*(5), 333-. https://doi.org/10.3390/children8050333

Moreover, the narrow focus on this sub-population hints to potential limitations in the design of prevention programmes.

The specific topics addressed by papers varied widely with some publications broadly discussing programmes available in a set country or region/s and making recommendations, others evaluating a particular programme, and others still shedding light on the perspectives of professionals, caregivers or other stakeholders. It is worth noting that all but 1 publication revolving around evaluation/impact of existing programmes relied on quantitative methodologies, and that most evaluations rested on the administration of psychological scales to service users participating in programmes in order to measure change and make the argument for programme effectiveness.

Programmes

The literature review led to the identification of 62 programmes of which 13 (21%) were primary prevention programmes, 21 (34%) secondary prevention programmes, 23 (37%) tertiary prevention and 5 (8%) programmes covered both secondary and tertiary prevention. The highest number of programmes identified in the literature were UK-focused (n=37; 60%), followed by Germany (n=8; 13%), Finland (n=4; 6%), Sweden (n=4; 6%), Israel (n=4; 6%). Several programmes covered multiple countries. All primary prevention programmes except 2 were addressed to children and young people of different ages (from 0-20) and in some cases, teachers. 2 programmes were designed for professionals in the tourism industry and adults, respectively. It should be noted that classification based on levels of prevention was not always straightforward. By way of example, several programmes target both individuals who have never acted on their impulses and people who have already committed sexualized violence against minors. Nevertheless, because such programmes are anonymous and run in countries where mandatory reporting is not a requirement, they are considered as secondary prevention interventions. Even if by definition, secondary prevention has the objective of preventing offending from taking place in the first place, in cases such as these, programmes were categorized as secondary prevention initiatives so as to avoid confusion and align with the legal context of reference.

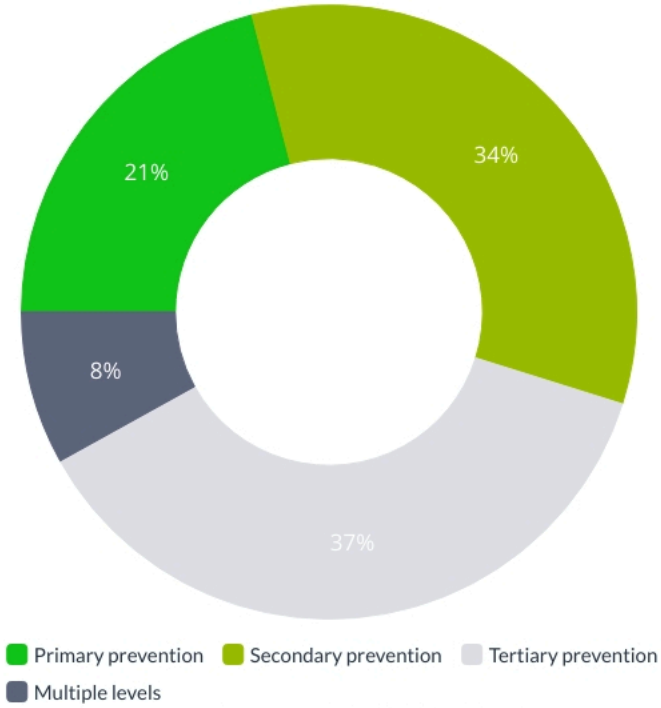


Figure 4: Level of prevention addressed by programmes identified in the literature

As regards secondary prevention programmes, 12 (57%) of them catered for adults at risk of committing child sexual abuse, defined in different ways based on the specific approach taken by the programme (please refer to discussion above for further clarifications). In several instances, the programme description specified that both men and women were included, while others made a generic reference to service users being "individuals". 2 (17%) of these programmes work exclusively with men. 9 programmes (43%) focus on youth at risk of committing sexual violence from as young as 6 years old. In most cases, the target group of said programmes was described as that of children with harmful or problematic sexual behaviours. Of programmes for youth, 2 (22%) were addressed to boys only. Several initiatives also catered for family members. Secondary programmes varied greatly in structure and format with a dominance of programmes based on therapy (individual, group or both) (n=12; 57%); online self-help programmes (n=5;24%); helplines (n=2; 10%); peer support programmes (online or offline) (n=1; 5%); programmes offering a combination of self-help and helpline (n=1; 5%).

The five programmes offering both secondary and tertiary prevention focused on adults at risk of committing CSA/adults who have already committed CSA (n=4; 80%) and children or youth at risk of committing CSA/juveniles who have sexually offended (n=1; 20%). Programmes are based on therapy (n=2; 40%), peer support (n=1; 20%); or a combination of self-help and helpline (n=1; 20%). One programme (n=1; 20%) ought to be considered as a support programme as it is not as structured as other initiatives.

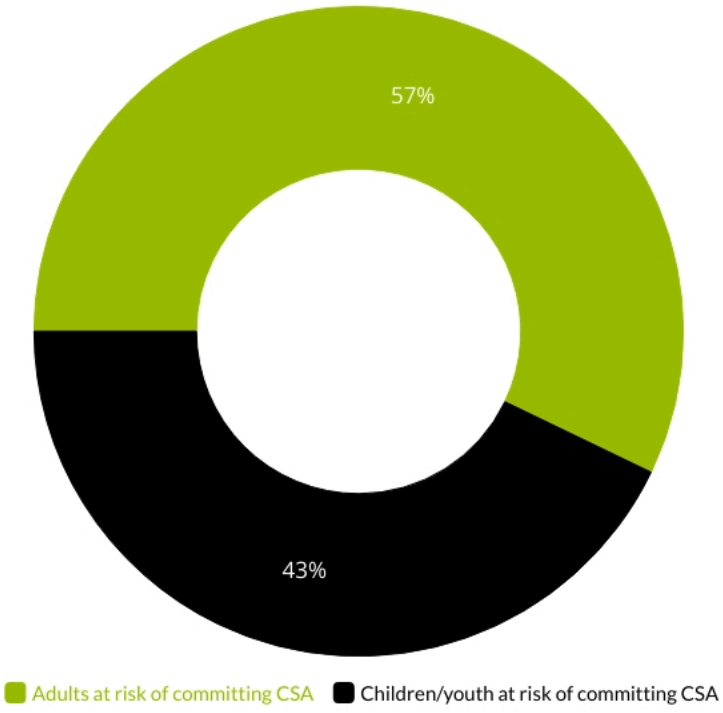


Figure 5: Target groups of secondary prevention programmes

In terms of tertiary prevention programmes, 14 (61%) of them are addressed to adults who have committed sexualized violence against minors. Of these, 6 (43%) cater for male service users only, including in the case of one organization, male service users with severe mental health issues who cannot join mainstream sex offender programmes and men who have experienced profound trauma. 2 programmes (14%) provide treatment for women specifically. 5 programmes (22%) work with juveniles who have sexually offended and 3 programmes (13%) focus on parents/carers, family members or friends. 1 programme (4%) supports couples where 1 of the parties has been convicted of sexual crimes against minors. In a similar manner to secondary prevention programmes, how programmes define their target groups varies greatly. Information on the setting of programmes was not always available, yet community-based settings, prison and residential facilities were represented in the sample. While most programmes rely on CBT, a great diversity of therapeutic approaches was mentioned, yet scant details were provided on how they are applied in practice. It is worth noting that one of the two programmes for women reported using a gender-informed perspective based on the "New Life" manual. It was challenging to gather systematic data on the structure of programmes, as well as their contents, given that each publication had distinct objectives and focus. Regardless, work on cognitions supporting sex offending against children, risk reduction, emotions, developing victim empathy, and criminogenic needs (dynamic risk factors) were recurrent themes.

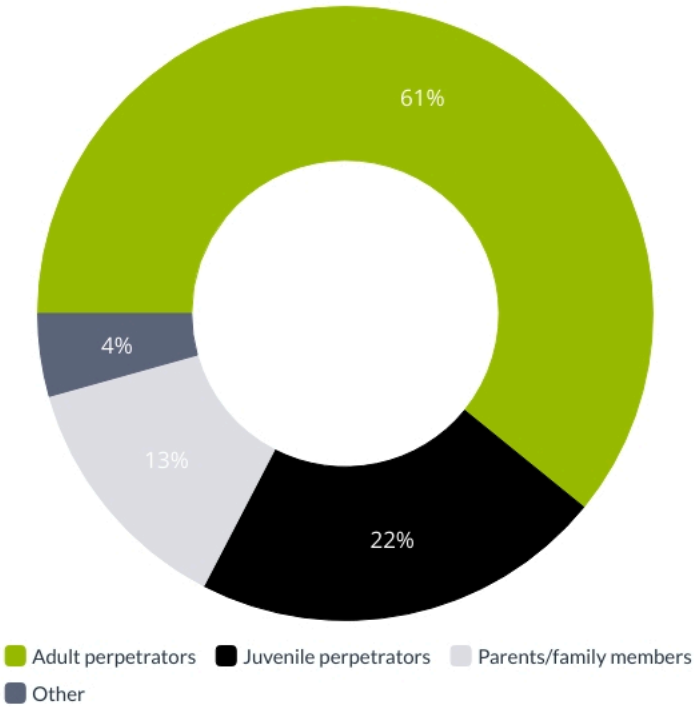


Figure 6: Target groups of tertiary prevention programmes

Questionnaires

27 organisations among the ones surveyed stated that they work with perpetrators of sexualized violence against minors. Of these, 26% (n=7) are based in Germany; 11% (n=3) are based in Spain; 7% respectively in Sweden (n=2), Italy (n=2) and Slovenia (n=2). The remaining organisations (n=11) are headquartered in one of the following countries: Austria, Bulgaria, Cyprus, Estonia, Iceland, Lithuania, Luxembourg, Malta, Norway, Romania and Turkey. As regards the context of work, most organisations are active in different organizational settings. 6 organisations (22%) work in prison, probation, alternatives to imprisonment and in the community. 5 organisations work in probation and alternatives to imprisonment (19%). 3 organisations (11%) work in prison, probation and alternatives to imprisonment; 3 organisations work in prison and probation (11%). 1 of these also offers mandated therapy after prison sentences are fulfilled. 4 organisations are active at community level only (15%), 1 organisation (4%) at probation level only and another organization (4%) at prison level only. 4 organisations (15%) selected 'other' indicating a children's home that handles cases of sexual abuse in minors; outpatient care; and a prevention and treatment unit.

Figure 7: Countries represented in the questionnaires

Level of prevention

The majority of organisations in the sample (n=18; 67%) are only active at tertiary prevention level. 15% (n=4) operate at primary, secondary and tertiary prevention, while the remainder engage either in primary and tertiary prevention only (n=2; 7%); secondary and tertiary prevention only (n=1; 4%), primary prevention only (n=1; 4%) or secondary prevention only (n=1; 4%).

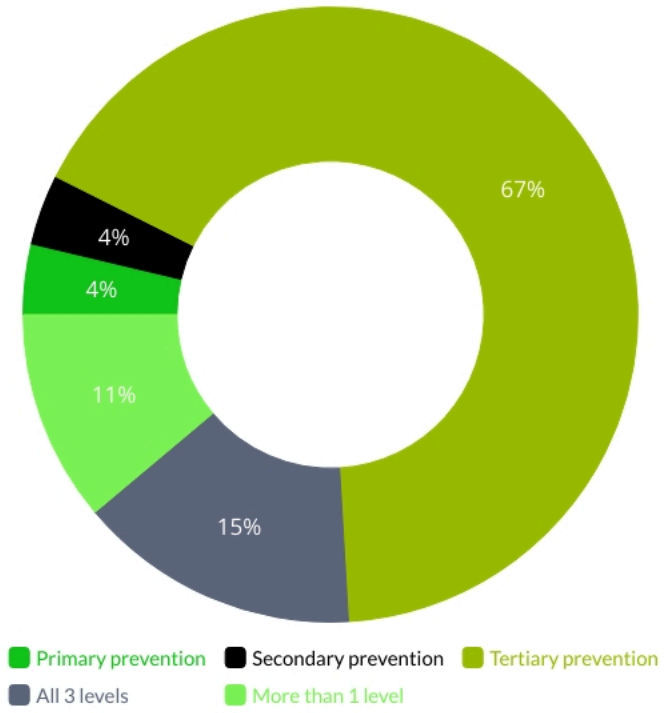


Figure 8: Prevention levels targeted by programmes identified via questionnaire

Multi-agency cooperation

Both at secondary and tertiary prevention level, organisations rely on manifold referral pathways. For organisations working on secondary prevention, the most common pathway are self-referral/referrals by family members (n=6; 26%); referral by the police (n=5; 22%); and referral by social and welfare agencies (n=5; 22%) followed by referral by courts (n=4; 17%) and in a minority of cases referral by victim services (n=1; 4%); child protection services (n=1; 4%); and alcohol and substance abuse treatment services (n=1; 4%).

As regards tertiary prevention, avenues for referrals encompassed the police, courts, prison, probation, social and welfare agencies and more. Out of the above-mentioned, the most common were referrals from courts (n=17; 30%); probation (n=12; 21%); and prison (n=11; 20%). Fewer referrals are effected by the police (n=6; 11%); social and welfare agencies (n=6; 11%); victim services (n=1; 2%) , child protection (n=1; 2%) or by via other routes (n=2; 4%). In the latter case, self-referrals in the context of an online programme were mentioned. The variety of referrals pathways for access to programmes is a testament to robust multi-agency collaboration.

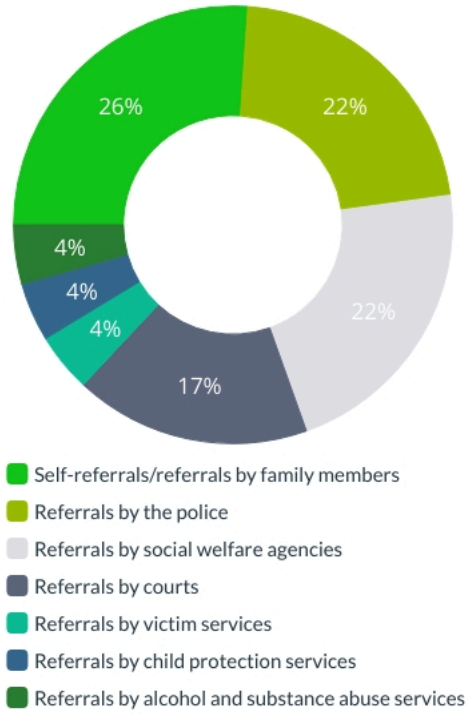


Figure 9: Referral pathways for secondary prevention programmes

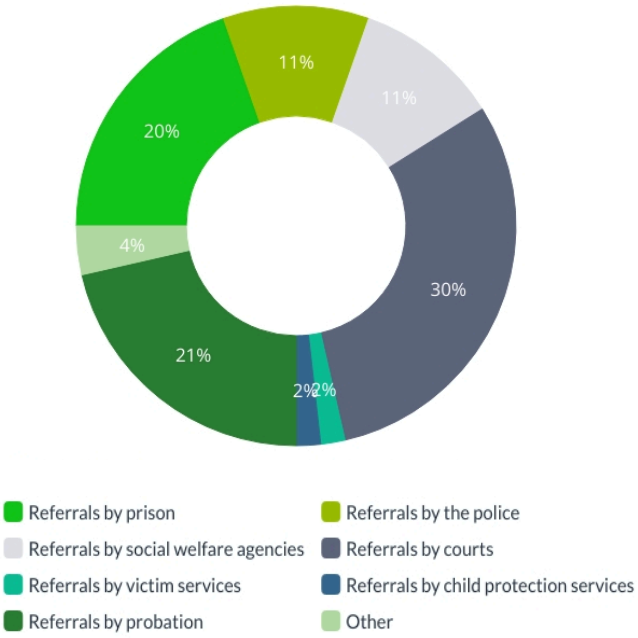


Figure 10: Referral pathways for tertiary prevention programmes

When it comes to victim support, this is offered only by 8 organisations in the sample (30%) as part of their programming, mostly without relying on cooperation with external organizations. Some organisations specified that they have a dedicated separate unit for victim support. The victim/survivor is generally contacted at the start of the program apart from 1 organisation (13%), which also contacts survivors in the course of program implementation. For all organisations there are multiple reasons for initiating victim contact. The most common involve sharing information about legal options (n=5; 14%), safety measures (n=5; 14%); and victim services (n=5; 14%). Other key reasons involve providing information about the programme and the methods utilised (n=4 respectively; 11%). Some organisations contact survivors to get a glimpse into their experience of violence and view of events (n=3; 8%), for the provision of emotional support (n=3; 8%), for risk assessment and safety planning purposes (n=3; 8%) and to clarify the limitations of programmes (n=3; 8%). Only in one instance (n=1; 3%) was programme evaluation mentioned as rationale for victim contact. One organization selected 'other' (n=1; 3%) highlighting that it contacts victims/survivors to facilitate access to assistance offered by other organisations. The questionnaires did not allow to explore the definition of survivors/victims utilized by organisations, making it arduous to truly grasp the practicalities of victim contact/support, particularly when minors – and potentially, their families – are involved, as is the case with CSA.

Figure 11: Percentage of organisations offering victim support

Assessing and managing risks

The majority of organisations surveyed (n=24; 89%) stated that they use risk assessments, with a small minority of respondents declaring that they do not (n=3; 11%). Alongside some of the most common tools employed to assess risk in the sex offender population such as the Static 99, the Stable-2007, the Acute 2007 or the LSI-R, a wide variety of tools were mentioned, including instruments which were described as "self-developed" and "non-standardized". In some cases, organisations stated that they use risk assessments developed specifically for male perpetrators to assess risk in women. While it was not possible to delve deeper into this via the questionnaire, it is interesting to note that organisations that work with migrants did not flag any challenges in employing risk assessments with this target group, given the research speaking to the disproportionate realities of precarity and marginalization among migrant populations, which in turn skew risk considerations, particularly with regard to dynamic risks[7].

Concerning the timing of risk assessment administration, most organisations that administer risk assessments do so at intake phase/immediately after (n=8; 33%). An equal share of organisations (n=6; 25% respectively) administer risk assessments at intake phase or immediately after and at the end of the program; or at intake phase or immediately after, halfway and at the end of the program. 4 organisations (17%) reported differing practices, which generally included more intensive assessments - i.e. after each session; on a 6 monthly basis; every month utilizing a specific risk assessment tool combined with 6-monthly and yearly assessments employing other risk assessment tools. In the following text box, a good practice example on risk assessment can be found (details of the programme are not given in order to guarantee anonymity).

[7] Långström, N. (2004). Accuracy of Actuarial Procedures for Assessment of Sexual Offender Recidivism Risk May Vary Across Ethnicity. *Sexual abuse : a journal of research and treatment*, 16. 107-20.

Figure 12: Percentage of organisations using risk assessments

For all offenders at intake or immediately after OASys risk assessment. STABLE is made after intake and every 6 months or a year or when there has been a significant event (based on the situation the case manager makes that situation). STATIC is made every 6 months or every year based on the case manager's opinion. ACUTE in probation is made every month or more frequent depending on the situation. OASys is made every year.

Good practice example – risk assessment management

Programme design and delivery

Target groups

Organisations generally declared working with multiple target groups. The most common profile for service users, mentioned by all organisations except 2 (93% of total) work were adult male perpetrators of sexualized violence. 19 organisations (70% of total) work with adult female perpetrators of sexualized violence in addition to males. 16 organisations (59% of total) work with juvenile males who have committed a sexual offence; out of these, 13 (48% of total) also work with juvenile females. 9 organisations (33% of total) work with adult males at risk of committing sexual abuse and of them, 6 (22% of total) also work with adult females at risk of committing sexual abuse. 7 organisations (26% of total) work with minors at risk of

committing sexual abuse. 6 organisations (22% of total) work with family members in addition to other service users.

The target groups of interventions further vary based on the prevention level. 33% (n=2) of the organisations working on primary prevention target exclusively adults, who are male only in one case; 33% (n=2) work with minors (male and female) only; and 33% (n=2) run programmes for adults and minors. Among organisations working on secondary prevention, 1 organisation (17%) works with male adults only, with the remainder (n=5; 83%) engaging with both adults and minors, albeit in the case of 2 organisations working with minors, only with boys. 50% (n=3) of organisations working on secondary prevention cater their secondary prevention services to both male and female service users, with 1 organisation also working with family members/parents or guardians. Finally, in the field of tertiary prevention, except for 1 organisation (4 % - 1 of 24) catering exclusively for adult male inmates, most organisations work with various service users at different stages of the criminal justice process (e.g. incarcerated, formerly incarcerated, on probation). In terms of gender of service users, 10 out of 24 organisations (42%) work exclusively with male service users. Moreover, 17 organisations (71% - 17 of 24) only work with adult service users with a small handful of organisations (n=7; 29%) catering for minors who committed CSA.

Figure 13: From left to right key data on users in primary, secondary and tertiary programmes represented in the sample

Programme duration and structure

The setting of programmes varied based on the prevention level. For primary prevention, this included schools and kindergartens, the street working with specific communities, the online environment and an outpatient department. For organisations operating at secondary prevention level, over half of organisations operate in multiple contexts, such as via a helpline (n=3; 27%), on their own premises (n=2; 18%;) in the community (n=2; 18%), online (n=1; 9%), in an outpatient department (n=1; 9%), or in other setting (n=2; 18%). For organisations working in tertiary prevention, work takes place mostly in the community (n=17 of 24; 71%); however,

while 10 organisations (42%) work exclusively in the community, 7 organisations (29%) combine community-based interventions with prison-based initiatives. In addition, 2 organisations (8%) combine prison-based work with work in probation and 1 organisation works in prison only (4%). 4 organisations (17%) chose 'other' which included the online environment (same programme detailed under secondary prevention section), probation and outpatient department. In the case of 1 organisation, the specific setting was unclear because vaguely articulated.

As regards professionals involved, psychologists were mentioned by all 27 organisations in the sample (100%) with 3 organisations (11%) declaring that they rely exclusively on this category of professionals. Nevertheless, a vast majority of organisations employ different professionals with complementary expertise. These include social workers (n=18, 23%); psychotherapists (n=16; 20%); mental health workers (n=6; 8%); educators (n=6; 8%); sexologists (n=2; 3%); psychiatrists (n=2; 3%); lawyers (n=1; 1%); sociologists (n=1; 1%) and police (n=1; 1%). The variety of professional expertise represented in the sample is a strong suit of analysed programmes, which aligns with the findings on multi-agency cooperation, and speaks to the benefits that can doubtless be reaped from multidisciplinary work environments.

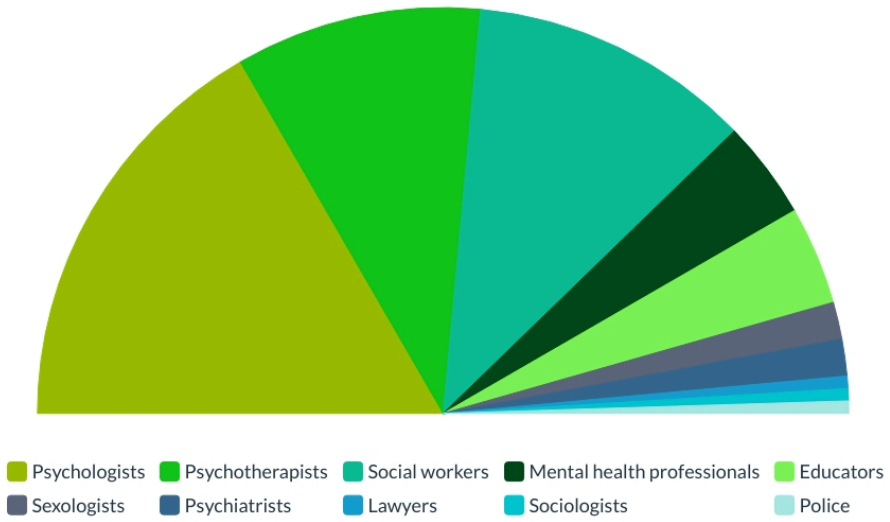


Figure 14: Professionals involved in programming

Team composition was also dependent on whether secondary or tertiary prevention work was being carried out. For secondary prevention programmes, it ranged between 1 female professional (n=1 organisation; 17%), 2 professionals (n=2 organisations; 33%); 3-4 (n 1 organisation; 17%) or over 4 (n=2 organisations; 33%). For tertiary prevention programmes, facilitation arrangements for organisations running 1-1 sessions (n=22) commonly involved a mixed team as preferred option (n=11; 50%), followed by 1 female facilitator (n=6; 27%) 1 male facilitator (n=4; 18%) and finally, a male team (n=1; 5%). The organisations doing group work rely mostly on a mixed team (n=5; 71%) or on 1 female facilitator only (n=2; 29%). It is worth noting that one organization pointed out that this is not out of choice but rather a result of lack of personnel. When team was selected, this was generally made up of 2 professionals.

Both secondary and tertiary prevention programmes generally rested on multiple access requirements, yet there were some variations in the requirements selected by organisations. For secondary prevention, only 1 organisation out of the ones working on this level of prevention (17%; 1 of 6) referred to one criterion only (age) with the remainder pinpointing multiple access requirements. These included signing an agreement/contract as a basis for programme participation (n=4; 17%); age (n=3; 13%) demonstrating a minimum motivation to participation (n=3; 13%); cognitive ability to follow the program (n=3; 13%); good enough knowledge of language (n=3; 13%); degree of limited confidentiality (against victim/survivor and/or referring institutions) (n=2; 9%); lack of addiction to alcohol or drugs (n=2; 9%) and lack of severe mental disorders (n=2; 9%). Of the organisations that pinpointed age as a key requirement indicated, only one caters for individuals over 18, the other distinguishes between minimum age for minors at 12 years and 18 for adults and did not indicate a specific age threshold referring in a generic manner to 'children and adolescents'.

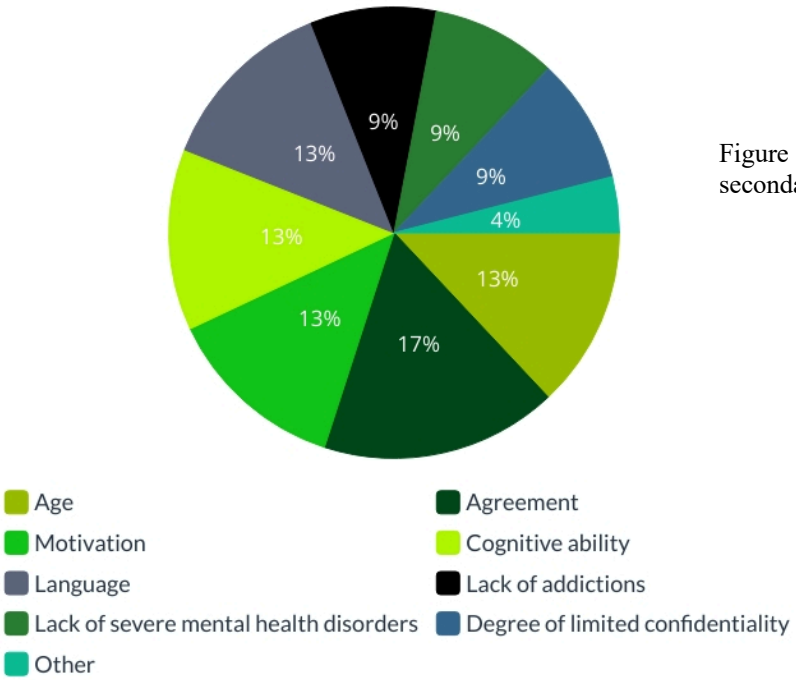


Figure 15: Minimum access requirements for secondary prevention programmes

For tertiary prevention, requirements for participation also rested upon the fulfilment of multiple conditions, but the combination of conditions varied across the sample. The most common requirement was a good enough knowledge of the language (n=18 responses; 17 %); followed by signing an agreement/contract as a basis for programme participation (n=17; 16%); demonstrating a minimum motivation to participate (n=16; 15%); and cognitive ability to follow the program (n=16; 15%). Albeit to a lesser degree, age (n=11; 10%); lack of severe mental disorders (n=9; 8%); lack of addiction to drugs or alcohol (n=5; 5%); fulfilling the facilitator's requirements for group work (when group is conducted) (n=5; 5%); and degree of limited confidentiality (e.g. against victim/survivor and/or institutions) (n=5; 5%) were also selected. 5% of responses (n=5) fell under other. Out of those that selected age as a requirement most cater for over 18s with 1 organisation mentioning the threshold being at 12, another at 14, 1 organisation at 15 and 4 organisations broadly referring to under 18s and specifying the need for consent to be obtained from parents as well as other specific requirements for access for minors.

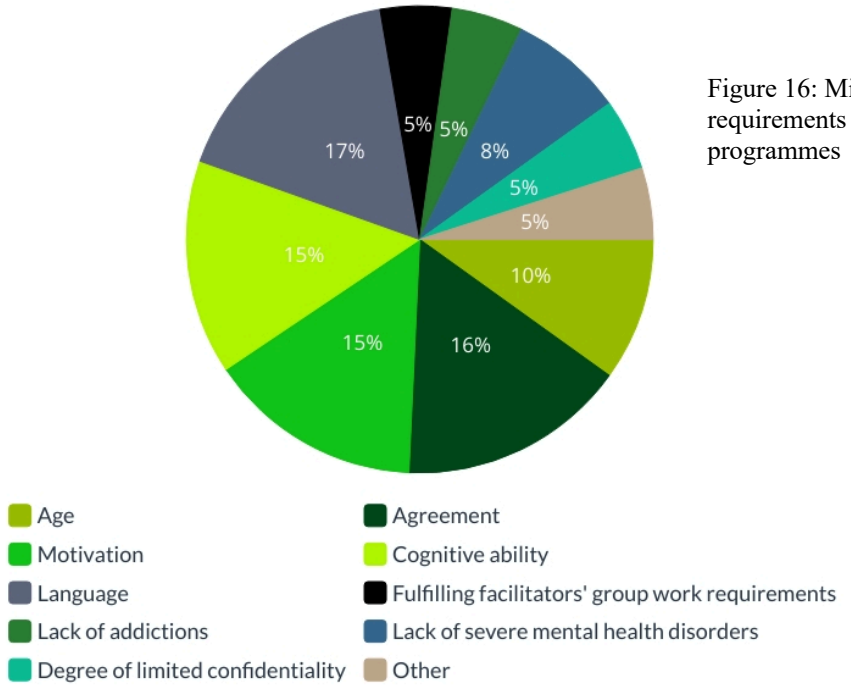


Figure 16: Minimum access requirements for tertiary prevention programmes

For primary prevention programmes, the frequency of programme delivery is predominantly regular (n=4; 67%) as opposed to one-off (n=2; 33%) where frequency varies between once a week, once a month, 3 times a year or on project basis. When it comes to secondary prevention programmes, most organisations working at this level of prevention (n=4 of 6; 67%) have no time limitation for programmes with only 1 organisation putting the cap at 1 year and another at 3 months and another at 3 months. As regards tertiary prevention programmes, duration varied based on whether the programme was 1-1 or in a group. Duration of 1-1 programmes generally had no limitation (n=10; 45%); was up to 3 (n=3; 14%), 6 months (n=3; 14%), 1 year (n=3; 14%) or 1-2 years (n=3; 14%). As regards group programmes, these last up to 3 months (n=2; 29 %), 6 months (n=2; 29%) or 1 year (n=2; 29%). 1 organisation runs group programmes lasting between 1 and 2 years (n=1; 14%). Despite these specificities, overall, 14 organisations in the total sample (52%) place no limitation on the duration of secondary or tertiary programmes.

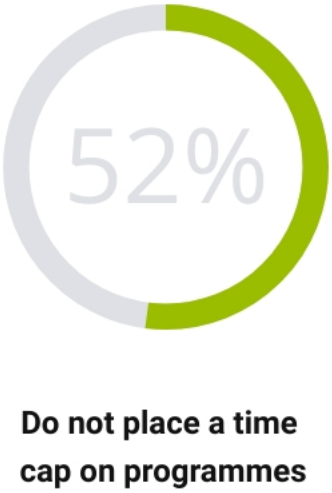
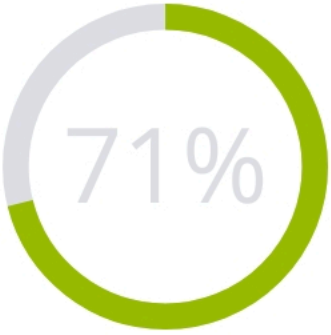


Figure 17: Percentage of secondary and tertiary prevention programmes that do not have time limitations

Intake procedures were also quite varied with the majority of secondary prevention programmes (n=5; 83%) declaring that they conduct an initial interview only as part of the intake process and 1 programme (17%) stating that no clearing phase takes place. In tertiary prevention, most programmes rely on an initial intake interview only (n=13; 57%), and in a number of cases (n=8; 35%) conduct individual counselling before moving on to group work. 3 programmes (13%) do not do intakes.

Both in secondary and tertiary prevention work there is a prevalence of 1-1 programmes. For secondary prevention programmes, 1-1 work is conducted by 83% of the sample (n=5;) with only 1 programme (17%) offering both 1-1 and group sessions. In the case of tertiary prevention, 1-1 work accounts for 71% of programmes (n=17) with 5 programmes (21%) engaging in both group and individual work and 2 programmes (8%) doing group work only.

of secondary prevention programmes conduct 1-1 work



of tertiary prevention programmes conduct 1-1 work

Figures 18 and 19: Percentage of secondary and tertiary prevention programmes conducting 1-1 work

For secondary prevention programmes, frequency of sessions is weekly or fortnightly. For individual sessions the duration ranges between 45 and 60 minutes, while group sessions range between 90 and 120 minutes. The only organization offering group sessions provides closed groups for adult males and male minors consisting of 6-10 participants. Groups are closed and take place fortnightly. With regard to tertiary prevention, frequency ranged from bi-weekly to weekly or fortnightly with several organisations highlighting specificities related to whether the programme was being run in prison or in probation where the intensity was higher in the former. In other cases, organisations underscored that frequency is tailored to the achievement of treatment goals – when the main goals are met, it is reduced. Duration of 1-1 session ranged between a min. of 45 minutes to a maximum of 120 minutes. Group sessions ranged between 50 minutes and 250 minutes.

The framework of groups is generally closed (n=4; 57%) with some organisations also running open/rolling groups (n=2; 29%) or both open and closed groups (n=1; 14%). Regarding the types of groups run, except for 3 organisations, most organisations which provide group treatment run different types of groups catering for different audiences. The majority of groups are adult male only groups (n=7; 58%); followed by adult female only groups (n=2; 17%); adult same sex groups (n=1; 8%); and groups for male minors (n=2; 17%).

Amongst the topics addressed in tertiary prevention group interventions which were mentioned by respondents there is empathy with the victim, self-control, motivation to change, relapse prevention; cognitive distortions; impulse control; behavior modification; lifestyle modifications; as well as in the case of one organization risk factors for recidivism in sexual offenses formulated in four themes: thoughts, feelings, sexuality and relationships.

Approach

Most organisations in the sample (n=20; 74%) apply a generic approach to their work with perpetrators of sexualized violence against minors, utilizing tools and methodologies which they rely upon in their work with the sex offender population more broadly. A minority of organisations (n=7; 26%) reported drawing upon specific approaches to child sexual abusers. 48% of organisations in the sample (n=12) declared that they use a gender-informed approach in their work with offenders. However, how this approach is implemented in practice with perpetrators of sexualized violence against minors wasn't always easy to grasp. Organisations were also asked whether they tailor their work to the needs of specific sub-groups within the child sexual abuser population, such as female sexual offenders and migrants. Only 5 organisations out of the 19 organisations working with female perpetrators of sexualized violence (26%) stated that they use a specific approach in their work with this target group. Moreover, only 1 organisation was able to qualify this approach as resting upon gender specific assessment of sexuality, with the remainder cursorily mentioning aspects related to personalised approaches without highlighting gender-specific elements. In relation to migrants, 8 organisations (30%) claimed to rely on a targeted approach which includes specific training for staff working with foreign service users, cultural awareness and sensitivity, ad-hoc programmes for people who do not speak the national language, linking service users with external support.

> 'We work with a gender perspective because we take into account the roles of masculinity and the stereotypes that can condition, never justify, violence. and how to change the model of masculinity'

Best practice – Gender-informed approach

Concerning specific treatment models, 74% of organisations (n=20) said that they use a specific treatment model. Most organisations rely on a combination of different models, with RNR (Risk, Needs and Responsivity) being the most commonly used, generally integrated with GLM (Good Lives Model). In numerous instances, respondents provided generic feedback mentioning cognitive-behavioural therapy or psycho-dynamic approaches, failing to pinpoint specific models identified in the sex offender literature.

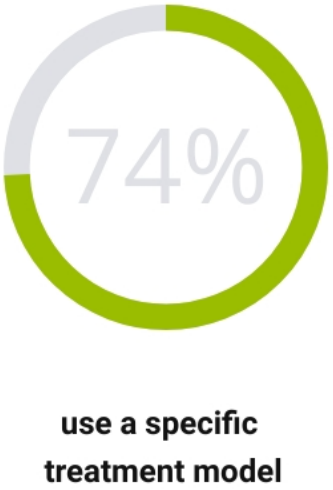


Figure 20: Percentage of organisations claiming they use a specific treatment model in their work

Quality assurance

Quality assurance involves different measures for participating organisations. Continuing education is the most frequent quality assurance measure used (n=23; 33%), followed by team sessions (n=22; 31%) and supervision (n=21; 30%). In 4 cases (6%) quality assurance tools which included intensive documentation, psychometric evaluation of outcomes, externalevaluation and review by a scientific committee in charge of managing the accreditation process, were mentioned. Regarding documenting systems, the most common methods used include case-oriented, standardized documentation of work (n=22; 25%); collecting annual statistics (n=18; 20%), gathering clients' demographic data systematically (n=17; 19%), developing annual activity reports (n=16; 18%) and case-oriented, non-standardized documentation of work and (n=13; 15%). Other documentation systems highlighted involved producing reports on a quarterly basis (n=1; 1%). Only 1 organisation declared it does not use any documentation system.

A little over half the organisations in the sample (n=14; 52%) measure the outcome of their work and the timing is generally when the client finishes the programme (n=13; 65%). The most common tools used to measure programme outcomes are service users' self-assessments by questionnaire (n=12; 33%) and facilitators' assessments (n=10; 28%). Other tools include official reports (police, court etc.) (n=7; 19%); victim/survivor's assessment by questionnaire or inventory (n=3; 8%); assessments involving family members (n=3; 8%); and other (n=1; 3%) consisting in 'talks with the offender after the programs to make sure the programme's work is not lost' and the offender embraces the learnings of the modules taken. In the following text box, a good practice example on evaluation can be found (details of the programme are not given in order to guarantee anonymity).

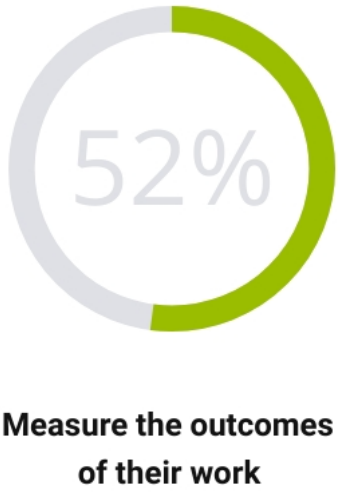


Figure 21: Percentage of organisations measuring the outcomes of their work

> We measure the outcome of our work after 1 month. Please note that we do assessments at two time points before treatment, weekly during treatment, at post treatment and at four weeks follow up. These measures are all part of our evaluation of the treatment efficacy.

Best practice – Quality assurance

Challenges

Respondents were asked to identify the main challenges to conducting work with child sexual abusers. Bearing in mind that most organisations indicated multiple challenges, the top challenge selected by 26% (n=17) of respondents was the lack of evidence-based programmes for sexual offenders, followed by lack of post-penal support in the community and lack of funding (n=13; 20% respectively); lack of specific competencies of staff (n=11; 17%) and lack of human resources to conduct rehabilitation activities (n=11;17%).

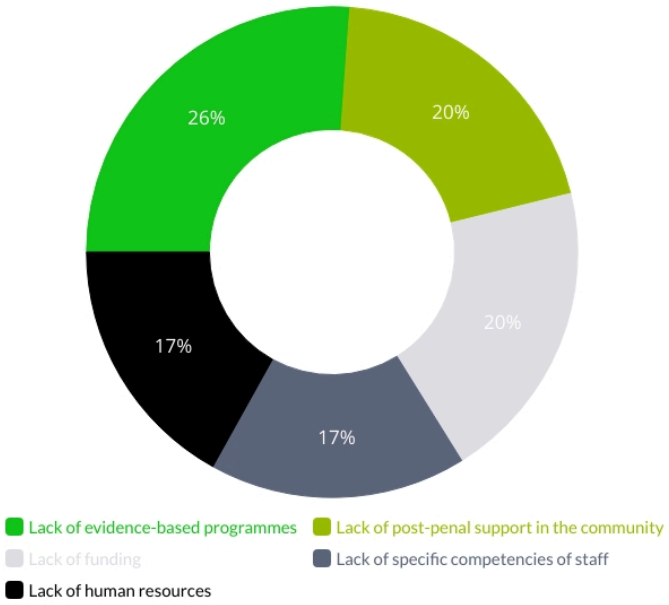


Figure 22: Main challenges faced by organisations in the sample in working with perpetrators of sexualised violence against minors

Discussion

The analysis contained herein sheds light on the types of programmes for perpetrators of sexualized violence against minors which exist in the European Region. The country coverage of programmes shows a dominance of UK and Germany, yet it should also be noted that the results are likely skewed by extant language barriers to publishing academic articles in languages other than English, and the fact that numerous programmes listed on the Lucy Faithfull Foundation database - a foundation headquartered in the UK - were included in the analysis. Although the data available on programmes presented in academic papers or grey literature is not thorough, several key insights can be gleaned.

First and foremost, the various understandings of primary, secondary and tertiary prevention, which are often couched in the specific legal frameworks and realities of reference countries, make it sometimes arduous to categorise programmes. As was previously highlighted, secondary prevention programmes are occasionally extended to individuals who have already committed child sexual abuse, yet the crime has not been reported. Moreover, there is scant reference to quarternary prevention in the literature with initiatives connected to this prevention level often falling under tertiary. Despite these challenges, relevant insights can be gleaned for each prevention level at which programmes are run.

Primary prevention initiatives appear to be addressed primarily to youth of different ages. While some programmes have been evaluated in multiple settings (see for instance Stepping Stones programme[8]), there appears to be scant information available about existing appraisals of other programmes. Interesting findings concern the format of secondary prevention programmes where therapy coexists alongside online self-help programmes, helplines and peer support initiatives. Some of these programmes – particularly those that are anonymous or involve online peer support – give rise to challenges around confidentiality, balancing anonymity with the establishment of a therapeutic relationship and measuring impact. In addition, the focus of several secondary prevention programmes on so-called 'minor-attracted persons' is a testament to the potential exclusion of individuals who are not sexually attracted to minors yet may be at risk of committing child sexual abuse, from numerous current initiatives. The literature speaks to the emphasis placed on quantitative methodologies for program evaluation where efforts go primarily toward measuring change in the perpetrator. There is a dearth of literature exploring programme standards or employing mixed methods (quantitative-qualitative) for programme evaluation. Aspects related to victim contact are hardly touched upon.

As concerns **questionnaire results**, these highlight promising practices in terms of multi-agency collaboration with organisations relying on a range of organisations for referrals; the existance of multi-disciplinary teams; and the lack of a time limitation on many programmes, which is sensible given the complexities of working with perpetrators of sexualized violence against minors. There are also several individual best practices concerning gender-specific approaches, risk assessments and measurement of outcomes (highlighted in text boxes), which point to quality interventions being rolled out at the European level.

[8] The Stepping Stones programme has been evaluated to varying degrees of rigour in different countries around the world. Further information available at this link: https://steppingstonesfeedback.org/resources/evaluation-evaluacion/

At the same time, the analysis raises a number of red flags. There is a rather widespread use of risk assessments for male sex offenders with the female sex offender population. These tools are based on baseline recidivism rate for men and the risk factors included in the scales for men are not valid for women. Recidivism rates for women are much lower (estimated as being lower than 3 %[9]), meaning that by using risk assessments for men on women there is an over-estimation of risk, resulting in more intensive treatment programmes and more stringent measures being rolled out. There are also ongoing debates around whether existing risk assessments can be used for men with different ethnic and cultural backgrounds[10], which organisations working with migrant populations should be aware of. Research has shown that the instability connected with many migration pathways often leading to weak social networks, homelessness and integration issues may disproportionately affect risk assessment outcomes[11]. Caution should thus be exercised when relying on such instruments.

Many risk assessments are complex and lengthy and thus require robust knowledge for their appropriate use. The frequency of risk assessments may also be a cause for concern, given that risk assessment in the sex offender field requires tools measuring both static and dynamic risks (criminogenic needs) where the latter ought to be administered at regular intervals to adequately assess the individual's progress on treatment goals. Even when it comes to risk assessments that have been tested with juveniles such as the JSOAP-II, there is still limited knowledge about their effectiveness[12]. The questionnaire findings underscore that there is partial understanding and awareness of risk assessment practices. This is likely related to the fact that research in the field is still ongoing and there lacks specific training and funding for training in the use of risk assessments for this target population.

Another potentially concerning finding relates to minimum access requirements. While relying on multiple access requirements may seem advantageous, it can also lead to 'cherry-picking' between service users and thus restricting the target group of interventions to those who are already most likely to adhere to treatment and potentially reap its results. There ought to be a compromise between effectiveness and inclusivity; coordination with services working in other areas – e.g. alcohol and substance abuse; mental health; disability – may help in striking a balance between the two. Given that there is a prevalence of 1-1 programmes in the sample, this consideration is all the more pertinent, as individual treatment should by definition be conducive to individualized approaches.

In terms of programme design and delivery, nebulousness over gender-specific approaches and approaches work with perpetrators of sexualized violence against minors is likely to have reverberations over programme implementation, quality and impact. There is a satisfactory number of organisations working with female sexual offenders in the sample, yet gender-specific approaches to the work with female perpetrators are often insufficiently articulated in relation to perpetrators of sexualized violence against minors. Similar considerations apply to

[9] Cortoni, F., Hanson, K. & Coache, M.E. (2010). The recidivism rates of females are low: A meta analysis. Sexual abuse: A Journal of Research and Treatment, 22(4), 387-401.
[10] Schmidt, S., Meer, E., van der, Tydecks, S. & Bliesener, T. (2018). How culture and migration affect risk assessment. European Journal of Pyschology applied to the legal context, 10(2), 65-78.
[11] Långström, N. (2004). Accuracy of Actuarial Procedures for Assessment of Sexual Offender Recidivism Risk May Vary Across Ethnicity. *Sexual abuse : a journal of research and treatment*, 16. 107-20.
[12] Christodoulides, T.E., Richardson, G., Graham, F., Kennedy, P.J. & Kelly, T.P. (2005). Risk assessment with adolescent sex offenders. The Journal of Sexual Aggression, 11(1), 37-48; Molnar, T., Allard, T., McKillop, N., & Rynne, J. (2022). Reliability and Predictive Validity of the Juvenile Sex Offender Assessment Protocol-II in an Australian Context. *International Journal of Offender Therapy and Comparative Criminology*, *66*(10-11), 1051-1070

the work with juvenile sex offenders. Intake procedures are occasionally minimal and it is concerning that there are organisations in the sample which declare that they do not conduct any intake intervew. Moreover, the dearth of trained professionals – and relatedly funding - flagged by several organisations in the sample conducive in some instances to group sessions being led only by one professional, the latter often being a woman. Research in the area of perpetrator work and sex offender treatment speaks to the impact of working on with this population on professionals' wellbeing[13]. Co-conduction may go a long way towards ensuring the smooth running of activities, creating more supportive environments and protecting professionals from adverse effects.

Measures related to quality assurance and evaluation are also worrisome – in particular, it is problematic that not all organisations offer surpervision. Moreover, measuring outcomes only at the end of the program and in some cases, exclusively via the client's self-assessments or the facilitator's reflection on the progress made, can only yield limited insights on programme effectiveness. In addition, as organizations themselves concede, the lack of evidence-based programmes for this target populations continues to act as a significant challenge.

Finally, unanswered questions concern what victim support/contact looks like in the context of programmes for perpetrators of sexualized violence against minors. Although contact with victims/survivors is essential to exploring the impact of programmes, it is not advisable to involve minors in this process. At the same time, where circumstances allow for it, family members can be involved both via the provision of therapeutic support or if at minimum, via victim contact. A degree of caution should also be exercised here, given the prevalence of child sexual abuse committed by family members[14] and the complex relationships which exist within family units. Interventions for both adults and minors exhibiting harmful sexual behaviours discussed in this paper involve, to varying degrees, family members in the process of rehabilitation, evidence of the fact that families already fall within the remit of many programmes. Further efforts should go toward incorporating the views of family members in measuring the impact of treatment.

Limitations

Limitations relate to the publications included in this paper being predominantly in English, thus potentially excluding promising programmes in other countries. The additional programmes which were included via consultation of the Lucy Faithfull Foundation database added significant content to the analysis, although it should be noted that it is likely that being the organization UK-based, there is likely an implicit preference for UK programmes, be it even as a result of ease of access to information on their structure and key features.

As regards questionnaires, these were disseminated among networks that already collaborate with WWP, which may have affected the nature of certain responses on context of work or other practices. The sample of questionnaire responses gathered is quite small and it was not possible to follow up with questionnaire respondents to glean further insights or qualify their responses in more depth. The questionnaire was structured based on three levels of prevention,

[13] Baum, N., & Moyal, S. (2020). Impact on Therapists Working With Sex Offenders: A Systematic Review of Gender Findings. *Trauma, violence & abuse*, *21*(1), 193–205. https://doi.org/10.1177/1524838018756120
[14] Lalor, K. & McElvaney, R. (2010). Overview of the Nature and Extent of Child Sexual Abuse in Europe. Protecting children from sexual violence - A comprehensive approach.

instead of four, due to the general confusion surrounding levels of prevention (which was reflected in some questionnaire responses) and the fact that quaternary prevention is still a relatively novel concept in the literature. Future research should consider quarternary prevention and incorporate qualitative interviews/focus groups to delve deeper into key aspects emerging from desk research/quantitative analysis.

Conclusions & ways forward

The mapping contributes to building knowledge about programmes for child sexual abusers in Europe. The findings highlight that there are a host of programmes which are currently being offered in the region, which span different levels of prevention, cater for a range of target populations and draw on different methodologies and approaches. The analysis demonstrates that are still many gaps in knowledge around the actual functioning of programmes and inconsistencies around the use of risk assessments, gender-specific approaches, training of professionals and more, pointing to the need for further research and the potential establishment of quality standards. A good place to start would be to conduct a thorough evaluation of programmes, resting not only on quantitative methodologies, but encompassing qualitative methods and involving service users, professionals and whenever applicable, victims in the process.

Ways forward

One of the main challenges in the field of treatment for perpetrators of sexualized violence against minors lies in the general lack of standards and baseline criteria for programmes. This results in very different practices and approaches in the field as it has been shown in this report. Efforts to group and categorise programmes, such as that of the Lucy Faithfull Foundation in the UK[15], which deserve praise, are still few and far between. Promising steps forward have been made by the European Comission's Joint Research Centre (JRC), via the recent development and publication of a taxonomy of classification criteria for prevention programmes on child sexual abuse and exploitation for programmes in Europe[16][17]. Several key criteria identified by the JRC are reflected in the analysis contained in this mapping. JRC work provides the basis for steps towards developing a European Union (EU) knowledge platform on CSA prevention initiatives, which will support EU Member States and other stakeholders in designing and in implementing tailor-made prevention policies according to their respective cultural and societal environments and needs. Hopefully these efforts will contribute to achieve greater consistency, transparency and accountability, which are still much needed in the field. Work towards common standards and operational guidelines should be an utmost priority to achieve these objectives.

[15] See: https://ecsa.lucyfaithfull.org/interventions

[16] Di Gioia, R., Beslay, L., Cassar, A. and Pawula, A. (2022). Classification criteria for child sexual abuse and exploitation prevention programmes, EUR 30973 EN, Publications Office of the European Union, Luxembourg. Retrieved from: https://publications.jrc.ec.europa.eu/repository/handle/JRC127262

[17] Di Gioia, R. and Beslay, L. (2023). Help seeker and Perpetrator Prevention Initiatives - Child Sexual Abuse and Exploitation, O`neill, G. editor(s), Publications Office of the European Union, Luxembourg, 2023, ISBN 978-92-76-60601-7, doi:10.2760/600662, JRC131323. Retrieved from: https://publications.jrc.ec.europa.eu/repository/handle/JRC131323

Recommendations:

Multi-agency cooperation
• Create standards and protocols of collaboration
• Offer combined capacity-building activities between perpetrator services, victim services and child protection services in order to get a better grasp of the nature of each other's work and familiarize with gender-specific and child-centred approaches

Survivor safety
• Survivor safety us an integral part of perpetrator programmes, yet the nature of child sexual abuse calls for a tailored approach. Programmes should liaise with Child Protection Services to exchange relevant information concerning the safety and wellbeing of the minor who has suffered sexual abuse. At the same time, family members should also be involved in programmes, through initial contact to ascertain their own support needs, via engagement in support groups offered by designated units or external organisations, and finally, for the purpose of programme evaluation.

Risk assessment and management
• Increase standardisation of risk assessment. It is crucial that programmes adopt procedures that ensure that risk is assessed in all cases and the safety of the survivor is kept in focus. To do this, programmes should strive to have clear protocols in place and use standardised, evidence-based tools beyond unstructured interviews with the client.
• Consider risk as a dynamic factor. To allow for proper risk management, its level should be assessed and reassessed continuously throughout the programme, not just at the beginning
• Offer training to staff in using risk assessments and expert guidance on how to approach risk assessment with female offenders and individuals belonging to ethnic and racial minorities

Programme design and delivery
• Carefully consider the target beneficiaries of secondary prevention programmes – avoid limiting programmes considered as "minor-attracted" and extend programming to all individuals at risk of committing CSA
• Ensure co-conduction of sessions and gender balance among facilitators
• Balance inclusivity and effectiveness/efficacy in defining minimum access requirements
• Ensure intake procedures are adequate – intakes should be 1-1 and no less than 3 hours
• Incorporate in online self-help programmes the option to reach out to a professional for therapeutic support (this is a measure foreseen by some programmes, but not systematically implemented)

Evaluation and quality assurance
• Use standardised and adequate tools for evaluation. In order to ensure positive outcomes, build trust and advocate for more funding, programmes should strive to use standardised and adequate tools designed to measure their effectiveness.
• Include the perspective of the survivor. The survivor's assessment of the progress achieved throughout the programme and its impact on her level of safety should be a critical part of the evaluation process. Design methodologies to incorporate the perspective of family members in cases of CSA.

Annex 1 - Countries included in the analysis

EU- EEA countries
Albania
Bosnia and Herzegovina
Georgia
North Macedonia
Republic of Moldova
Russia
Ukraine
United Kingdom

Annex 2 – Publications included in the analysis

Publication details	Country	Methodology	Level of prevention	Target groups as described in publication	Target groups as categorized in the analysis	Conclusions
Adebahr,R., Söderström, E. Z., Arver, S., Jokinen, J., & Öberg, K. G. (2021). Reaching Men and Women at Risk of Committing Sexual Offences – Findings From the National Swedish Telephone Helpline PrevenTell. *Journal of Sexual Medicine,* 18(9), 1571–1581.	Sweden	Qualitative research with men and women who contacted the helpline	Secondary prevention	Men and women at risk of committing sexual offences incl. CSA	Adults at risk of committing CSA	Most callers expressed pattern of behaviors associated with sexual violence, and among them a substantial number had committed illegal acts including severe violence against minors. The majority of help-seeking individuals were referred to appropriate healthcare units
Aebi, M., Krause, C., Barra, S., Vogt, G., Vertone, L., Manetsch, M., Imbach, D., Endrass, J., Rossegger, A., Schmeck, K., & Bessler, C. (2022). What Kind of Therapy Works With Juveniles Who Have Sexually Offended? A Randomized-Controlled Trial of Two Versions of a Specialized Cognitive Behavioral Outpatient Treatment Program. *Sexual Abuse*, 34(8), 973–1002.	Switzerland	Quantitative research aimed at assessing treatment effectiveness	Tertiary prevention	Juveniles who have sexually offended	Juveniles who have sexually offended	Scales used to measure treatment effectiveness among juvenile SO. Considerations on need for individualised treatment
Biel, K. (2022). Prevention of sexual abuse against children and young people on the example of the Child Protection Centre in Kraków *The Person and the Challenges, 12 .201–212.*	Poland	Theoretical piece (descriptive)	Primary and potentially, secondary prevention	Religious officials	Religious officials	Conclusions relate to prevention initiatives to contrast the phenomenon of CSA in the church
Briken, P., Boetticher, A., Krueger, R. B., Kismödi, E., & Reed, G. M. (2019). Current Legal Situation for Patients with Paraphilic disorders and Implications of the ICD-11 for Paraphilic Disorders for Germany. *Journal of*	Germany	Theoretical piece (analytical)	Across the 3 levels but nature of conclusions more relevant	Patients with paraphilic disorders	Multiple target groups	Observations on the views and needs of 'individuals with sexual deviances' vis-a-vis treatment in Germany.

Sexual Medicine, 16(10), 1615–1622. https://doi.org/10.1016/j.jsxm.2019.07.011			to secondary prevention			
Bustnay, T.G. (2020). Group Intervention with Parents of Juvenile Sex Offenders. *Journal of Child Sexual Abuse*, 29(3), 278–294.	Israel	Qualitative research aimed at exploring a group intervention with parents of juvenile sex offenders	Tertiary prevention	Juvenile sex offenders	Juveniles who have sexually offended	In the case of JSO, parental involvement in the treatment is valuable in preventing a recurrence of adolescents' antisocial behavior in general and offensive sexual behavior in particular and is more effective than group or individual therapy alone.
Campbell, F., Booth, A., Hackett, S., & Sutton, A. (2020). Young People Who Display Harmful Sexual Behaviors and Their Families: A Qualitative Systematic Review of Their Experiences of Professional Interventions. *Trauma, Violence, & Abuse*, 21(3), 456–469.	UK Ireland	Qualitative systematic review	Across the 3 levels	Young people who display HSB and their families	Multiple target groups	Five major themes were identified from the perspectives of youths and their carers as being central to successful interventions. These were the key role of the practitioner/therapist, the key role of parents/caregivers, seeing the bigger picture, communication and disclosure, and developing self and learning skills. The paper advocates for whole person approach.
Di Gioia, R., Beslay, L., Cassar, A. and Pawula, A. (2022). Classification criteria for child sexual abuse and exploitation prevention programmes, EUR 30973 EN, Publications Office of the European Union, Luxembourg, ISBN 978-92-76-46993-3 (online), doi:10.2760/725913 (online), JRC127262.	Europe	Qualitative research based on expert wokshop	Across the 3 levels	People who fear they may offend; Persons undergoing criminal proceedings or after criminal proceedings, including Convicted offenders in prisons;	Multiple target groups	Classification criteria for CSAE prevention programmes.

				Convicted offenders after they leave the prison to fight against recidivism.		
Engel, J. Körner, M., Schuhmann, P., Krüger, T. H. C., & Hartmann, U. (2018). Reduction of Risk Factors for Pedophilic Sexual Offending. *Journal of Sexual Medicine*, 15(11), 1629–1637.	Germany	Quantitative research aimed at assessing treatment effectiveness	Secondary prevention	Men at risk of pedophilic sexual offending	Adults at risk of committing CSA	Emphasis on the importance of secondary prevention programs able to prevent offending before it takes place.
Finch, M., Featherston, R., Chakraborty, S., Bjørndal, L., Mildon, R., Albers, B., Fiennes, C., Taylor, D. J. A., Schachtman, R., Yang, T., & Shlonsky, A. (2021). Interventions that address institutional child maltreatment: evidence and gap map. *Campbell Systematic Review*, 17(1), e1139–n/a.	Europe	Evidence Gap map	Across the 3 levels	Perpetrators of child maltreatment	Multiple target groups	Dearth of high-quality studies that evaluate interventions across a broader range of institutional contexts and maltreatment types.
Forni G., Pietronigro A., Tiwana N., Gandolfi C.E., Del Castillo G., Mosillo M., Pellai A. (2020). Little red riding hood in the social forest. Online grooming as a public health issue: a narrative review. *Ann Ig.,* 32(3):305-318.	NL	Systematic review on online grooming	Across the 3 levels	Perpetrators of online grooming	Multiple target groups	Notes a fragmented approach in prevention strategies and knowledge gaps on online grooming.
Fromberger, P., Schröder, S., Bauer, L., Siegel, B., Tozdan, S., Briken, P., Buntrock, C., Etzler, S., Rettenberger, M., Leha, A., & Müller, J. L. (2021). @myTabu-A Placebo Controlled Randomized Trial of a Guided Web-Based Intervention for Individuals Who Sexually Abused Children and Individuals Who Consumed Child Sexual Exploitation Material: A Clinical Study Protocol. *Frontiers in Psychiatry*, 11, 575464–575464.	Germany	Clinical trial	Tertiary prevention	Male and female perpetrators of CSA/CSEM	Adults who have committed CSA	The clinical trial focuses on testing of a web-based intervention. Conclusions are preliminary.
Gillespie, S.M., Bailey, A., Squire, T., Carey, M. L., Eldridge, H. J., & Beech, A. R. (2018). An Evaluation of a Community-Based Psycho-Educational Program for Users of Child Sexual	UK	Quantitative research aimed at assessing	Secondary prevention	Adult males investigated for CSEM	Adults at risk of committing CSA	Use of various scales (depression, self-esteem etc) among adult male users of CSEM under investigation demonstrating that a large proportion of men could be

Exploitation Material. *Sexual Abuse*, 30(2), 169–191.		treatment effectiveness				categorized as severe or extremely severe for levels of depression, anxiety, and stress relative to the general population. It remains unclear whether or not levels of symptom severity observed pre-program reflect trait levels that may have influenced the individuals' offending behavior, or an increase in affective difficulties relating to any ongoing police investigation or criminal proceedings.
Goodier, S. & Lievesley, R. (2018). Understanding the Needs of Individuals at Risk of Perpetrating Child Sexual Abuse: A Practitioner Perspective. *Journal of Forensic Psychology Research and Practice*, 18(1), 77–98.	UK	Qualitative research with professionals	Secondary prevention	Practitioners working with individuals at risk of perpetrating child sexual abuse	Adults at risk of committing CSA	Importance to ensure prompt access to service and secure funding for programmes.
Gorden, C., Stanton-Jones, H., Harrison, J., & Parry, H. (2021). Experiences of young people with harmful sexual behaviours in a residential treatment programme: a qualitative study. *The Journal of Sexual Aggression*, 27(2), 153–166. https://doi.org/10.1080/13552600.2020.1787533.	UK	Qualitative study with young people with harmful sexual behaviours in a residential programme	Tertiary prevention	Young people with harmful sexual behaviours	Juveniles who have sexually offended	Young people with HSB are more likely to re-offend non sexually; working with family members is very important.
Hansmann, B.C. & Eher, R. (2020). Assisting decisions in child protection service institutions with the RIC – The Risk Indication in Child sexual abuse. *Child Abuse & Neglect*, *109*, 104652–10.	Austria	Quantitative research exploring use of RIC risk assessment (Risk Indication in Child sexual abuse)	Tertiary prevention	Male perpetrators of CSA	Adults who have committed CSA	TheRIC is a helpful risk assessment tool for child support services, as it is not overly technical and can provide a good assessment of risk.

Heasman, A. & Foreman, T. (2019). Bioethical Issues and Secondary Prevention for Nonoffending Individuals with Pedophilia. *Cambridge Quarterly of Healthcare Ethics*, 28(2), 264–275.	Germany UK Netherlands	Desk research	Secondary prevention	Non-offending individuals with paedophilia	Adults at risk of committing CSA	There is a significant, and arguably urgent, need for more research and intervention for people with pedophilia who are not involved with the criminal justice system.
Hirschtritt M.E., Tucker D., Binder R.L. (2019). Risk Assessment of Online Child Sexual Exploitation Offenders. *J Am Acad Psychiatry Law,* 47(2):155-164. doi: 10.29158/JAAPL.003830-19. Epub 2019 Apr 15.	Europe	Desk research	Tertiary prevention	Online CSE offenders	Adults who have committed CSA	Online offenders may demonstrate different demographic characteristics and criminal-offense histories when compared with contact offenders. The former tend to have greater formal education and to be younger, of higher socioeconomic status, and employed. In addition, the limited available data suggest that most online offenders without a history of past contact offenses are unlikely to engage in future contact offenses. Nonetheless, some online offenders may simultaneously be at risk of recidivism for contact offenses or for subsequent online offenses.
Jackson, T., Ahuja, K., & Tenbergen, G. (2022). Challenges and Solutions to Implementing a Community-Based Wellness Program for Non-Offending Minor Attracted Persons. *Journal of Child Sexual Abuse*, 31(3), 316–332.	Europe	Desk research	Secondary prevention	Non-offending minor-attracted persons	Adults at risk of committing CSA	Conclusions relate primarily to programs in the USA and the challenges of offering supports to NOMAPs with mandatory reporting.
Keiski, P., Helminen, M., Lindroos, M., Kommeri, H., & Paavilainen, E. (2019). Female-perpetrated family violence-Effectiveness of a psychodynamic group intervention. *Health Care for Women Internationa*l, 40(3), 328–344. https://doi.org/10.1080/07399332.2018.1548622	Finland	Quantitative research aimed at assessing treatment effectiveness 9focus on women)	Tertiary prevention	Women who have committed family violence against partners or children	Adults who have committed CSA	Use of the Preventing Violence and Increasing Self-Knowledge Scale (PVISS) demonstrated an improvement in all areas of self-knowledge significantly from pretest measurement to follow-up

Kewley, S., Mhlanga-Gunda, R., & Van Hout, M.-C. (2023). Preventing child sexual abuse before it occurs: examining the scale and nature of secondary public health prevention approaches. *The Journal of Sexual Aggression*, 29(1), 1–33. https://doi.org/10.1080/13552600.2021.2000651	Europe	Review	Across the 3 levels	Adults and children at risk of committing CSA	Multiple target groups	Emphasises the crucial importance of secondary prevention
King-Hill, S., Gilsenan, A., & McCartan, K. (2023). Professional responses to sibling sexual abuse. *The Journal of Sexual Aggression*, 1–15.	UK	Qualitative research exploring professionals' responses to sibling sexual abuse	Tertiary prevention	Professionals working on sibling sexual abuse from both the perspective of "children who harm" and survivors	Juveniles who have sexually offended	Without providing resources and language for practitioners to address harmful sexual behaviour, the issue of SSA often remains hidden or obscured by other problems within the family structure. Whilst emergent research (King-Hill et al., 2021) attempts to address the need to support practitioners in recognising and intervening in cases of SSA, much more work is needed in this area to ensure young people and families experiences and needs are recognised
Knack, N., Winder, B., Murphy, L., & Fedoroff, J. P. (2019). Primary and secondary prevention of child sexual abuse. *International Review of Psychiatry* (Abingdon, England), 31(2), 181–194.	Germany UK	Desk research	Primary and secondary prevention	Multiple target groups or not specified	multiple target groups	Recommendations for improvement of programmess. Misconceptions can lead to an inflation of risk associated with children who harm and in turn, can lead to disproportionate catastrophising responses to behaviour that might actually be developmentally normal. Recommendations include: a) implementation of a cohesive national approach and guidance, with designated services in each locality; b) bespoke training and professional development opportunities for professionals; c)

						early identification of intervention pathways and communication across agencies from referral
Konrad, A., Amelung, T., & Beier, K. M. (2018). Misuse of Child Sexual Abuse Images: Treatment Course of a Self-Identified Pedophilic Pastor. *Journal of Sex & Marital Therapy*, 44(3), 281–294. https://doi.org/10.1080/0092623X.2017.1366958	Germany	Case study	Secondary prevention	Self-identified pedophilic pastor	Adults at risk of committing CSA	Considerations on advantages of lack of mandatory reporting for access to services.
Levenson, G., Mesias, J.S., Kavanagh, G. S. & Charles, J. (2019). "I Can't Talk About That": Stigma and Fear as Barriers to Preventive Services for Minor-Attracted Persons. *Stigma and Health* (Washington, D.C.), 4(4), 400–410.	UK	Mixed methods research for to assess barriers to access to prevention services for minor-attracted persons	Secondary prevention	Minor-attracted persons	Adults at risk of committing CSA	The experience of stigma was by far the most salient theme that emerged from the qualitative responses provided by the participants. Shame and judgment appear to be a significant barrier to MAPs seeking professional services from formal supports.
Martínez-Catena, A. & Redondo, S. (2022). Treatment and Therapeutic Change of Individuals Imprisoned for Child Abuse in the Barcelona Study on Sex Offenders. *Journal of Interpersonal Violence*, *37*(19-20).	Spain	Quantitative research aimed at assessing treatment effectiveness	Tertiary prevention	Individuals imprisoned for CSA	Adults who have committed CSA	Therapeutic needs/readiness to change was assessed with the aid of various tools and scales. Six of the nine therapeutic needs assessed here favorably improved following treatment: social self-esteem, assertiveness, acceptance of the use of force in sexual interactions, impulsivity, aggressiveness, and feelings of loneliness. The global PASSO score (Psychological Assessment Scale for Sex Offenders) also increased after treatment participation. This highlights a global therapeutic improvement

						of the treated subjects, with a medium but relevant effect size found in the pre- and post-treatment comparison. On the contrary, the variables social self-esteem, readiness to change, cognitive distortions on child abuse and sexual anxiety did not change after treatment. Nonetheless, the fact that social self-esteem and sexual anxiety showed strong correlations with other therapeutic variables, which also were objectives of the treatment, suggests that both variables might improve in line with related therapeutic factors and be empowered by them. Regarding readiness to change, at the pre-treatment assessment the participants showed scores close to the top of the range. Therefore, although the mean of readiness to change increased in the post-treatment period, the pre-post difference did not reach statistical significance. Loneliness has probably been underestimated by previous research, both as a correlate of sexual offending and as an objective of treatment. Concerning cognitive distortions and justification of crime, no high deficiencies were initially found in the sample. Cognitive schemas related to children as sexual

						partners but also different justifications involving the use of force in sexual interactions. These results could reflect the notion that men who sexually abuse children can also show antisocial schemas. A practical result is that probably both types of cognitive distortions and justifications, related to children abuse and to the use of force in sexual interactions, should be goals of treatment. An implication of the results of this study for general knowledge is that the relationship observed between distinct criminogenic or therapeutic needs (cognition, social skills, emotions), susceptible to mutual improvement, could be critical for a global therapeutic change of the individuals. Hence, a better understanding of the interrelations between different therapeutic ingredients, and their specific and global effects, could help practitioners to work more efficiently with the diversity usually found in participants in treatment.

Meinck, F., Murray, A. L., Dunne, M. P., Schmidt, P., & Nikolaidis, G. (2021). Factor structure and internal consistency of the ISPCAN Child Abuse Screening Tool Parent Version (ICAST-P) in a cross-country pooled data set in nine Balkan countries. *Child Abuse & Neglect*, 115, 105007–105007.	Albania Bosnia Bulgaria Croatia Northern Macedonia Greece Romania Serbia Turkey	Quantitative – test the ICAST-P measuring physical, emotional and sexual violence and neglect of an index child in the past year and over a lifetime using parent report.	Tertiary prevention	Caregivers	Caregivers	The study found a high prevalence of physical and emotional violence and neglect, suggesting that parents may not underreport their children's exposure to most types of violence as much as previously assumed.
Mokros, A. & Banse, R. (2019). The "Dunkelfeld" Project for Self-Identified Pedophiles: A Reappraisal of its Effectiveness. *Journal of Sexual Medicine*, 16(5), 609–613.	Germany	Theoretical piece (analytical)	Secondary prevention	Self-identified pedophiles	Adults at risk of committing CSA	Critique of existing program evaluation. Treatment may not be as effective as originally thought. Statistically, the reduction in dynamic risk factors cannot be distinguished from nil.

Mooney. (2022). A systematic review of the United Kingdom's contact child sexual exploitation perpetrator literature: Pointing a way forward for future research and practice. *Journal of Investigative Psychology and Offender Profiling*, 19(2), 40–57.	UK	Systematic literature review	Across the 3 levels	Child sexual exploitation perpetrators	Multiple target groups	Current sex offender treatment programmes (SOTP) are based on responses to the more mature, often paedophilic sex offender, conducted via a group based approach, likely to be over-subscribed due to limited resources and an increase in numbers of sex offenders -SOTP for younger perpetrators who might struggle with the group dynamics were critiqued, particularly as the topics discussed failed to acknowledge the role of technology (arguably even more relevant to younger.The future of CSE perpetrator intervention would therefore be more relevant to address the types of offending (i.e., gang related) and would involve ways to re-engage offenders back into society, particularly if they are more likely to be younger offenders.

Patterson, A., Ryckman, L., & Guerra, C. (2022). A Systematic Review of the Education and Awareness Interventions to Prevent Online Child Sexual Abuse. *Journal of Child & Adolescent Trauma*, 15(3), 857–867.	UK Belgium Finland	Systematic literature review	Primary prevention	Youth	youth	Mixed outcomes on the effectiveness of programmes. The 'Stop It Now!' (Hudson, 2018) intervention was mostly effective due to the participants increasing their knowledge but recognized that improvement was still needed in understanding when to act. Several interventions were labeled as 'somewhat effective' in increasing safety knowledge; however, they were found to be ineffective in changing behavior, including the '10-minute presentation' and the 'three educational packages on contact, content and commercial risks'. Several interventions were inconclusive because their results were too ambiguous to form a conclusion
Rimer, J.R. (2021). Discipline as Prevention: Psychoeducational Strategies in Internet Sexual Offending Group Programs. International *Journal of Offender Therapy and Comparative Criminology*, 65(15), 1607–1628.	UK	Ethnographic and qualitative research assessing programme effectiveness	Secondary and Tertiary prevention	Males apprehended/convicted for viewing and possessing CSEM	Multiple target groups	The programme has the men reframe knowledge about themselves, offending factors, and perceptions of offending. Crucial is that it encourages discipline related to the online world. Tools for program improvement could include information about offline relationships, social networks, and interactions, as well as details about the same foci online, along with perceptions of online anonymity, visibility, “realness,” social norms, and morals.

Schröder, S., Bauer, L., Müller, J. L., Briken, P., Fromberger, P., & Tozdan, S. (2023). Web-Based Interventions for Individuals who Committed Sexual Offenses Against Children: Development, Evaluation, and Implementation. *Criminal Justice and Behavior*, 50(2), 235–251. https://doi.org/10.1177/00938548221140351	International (online)	Review of Web-based interventions	Secondary and tertiary prevention	Individuals who committed sexual offenses against children but have not come to the attention of the authorities	Multiple target groups	Considerations of pros and cons of web-based interventions
Sousa, M., Andrade, J., de Castro-Rodrigues, A., & Gonçalves, R. A. (2023). The Effectiveness of Psychological Treatment in Adult Male Convicted for Sexual Offenses Against Children: A Systematic Review. *Trauma, Violence & Abuse*, 24(3), 1867–1881. https://doi.org/10.1177/15248380221082080.	Europe	Review	Tertiary prevention	Adult Male Convicted for Sexual Offenses Against Children	Adults who have committed CSA	Cognitive-behavioral therapy with a relapse prevention approach was the most frequent modality found in child sexual offending treatment. Besides, different criminogenic and non-criminogenic factors emerge as targets for intervention.
Stephens, S., Elchuk, D., Davidson, M., & Williams, S. (2022). A Review of Childhood Sexual Abuse Perpetration Prevention Programs. Current Psychiatry Reports, 24(11), 679–685. https://doi.org/10.1007/s11920-022-01375-8	Ireland UK Germany	Review	Secondary prevention	Individuals who are concerned about their risk of CSA perpetration, individuals with a sexual interest in children, and/or those who are concerned about the risk of perpetration of CSA	Adults at risk of committing CSA	Categorises secondary prevention programs as helplines, anonymous self-guided interventions, and non-anonymous therapy programs. Interesting conclusions: Another related consideration is that most of the perpetration prevention programs have been predominantly developed for adults with a sexual interest in children. Research has suggested that 40 to 50% of those who offend against children do not have a sexual interest in children and offend for other reasons. If programs only focus on those with a sexual interest in children, they risk missing a sub-set of individuals who may present with other risk factors for sexual offending and are interested in this type of programming. + lack

						of programs for women and gender diverse people
Subramonian A, Severn M. (2020). Sex Offender Treatment Programs Delivered In-Person or Virtually for Adults Convicted of Sexual Offences in Various Settings: A Review of Clinical Effectiveness and Guidelines [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health.	Uk Norway	Systematic literature review	Tertiary prevention	Adults Convicted of Sexual Offences in Various Settings	Adults who have committed CSA	Effectiveness of programs in the community vs custodial setting, virtual or F2F. Importance of considering cultural differences in the design of programmes.
Suojellaan Lapsia, Protect Children ry. (2022). ReDirection Project Final Report. Available at: https://www.suojellaanlapsia.fi/en/post/redirection-final-report-3	Finland	Project report	Secondary prevention	Individuals at risk of committing CSAM	adults at risk of committing CSA	Feedback from users of the ReDirection Self-Help Programme suggests that the programme successfully decreases CSAM use.
Tener, D., Newman, A. , Yates, P. and Tarshish,N. 2020. Child Advocacy Center intervention with sibling sexual abuse cases: Cross-cultural comparison of professionals'	Israel	Qualitative research examining professionals	Tertiary prevention	Staff members working on sibling sexual abuse	Juveniles who have sexually offended	Challenges and support needs of parents dealing with SSA

perspectives and experiences, *Child Abuse & Neglect*, 105.		' perspective on sexual abuse cases involving siblings				
Wild, T.S.N., Fromberger, P., Jordan, K., Müller, I., & Müller, J. L. (2019). Web-Based Health Services in Forensic Psychiatry: A Review of the Use of the Internet in the Treatment of Child Sexual Abusers and Child Sexual Exploitation Material Offenders. *Frontiers in Psychiatry*, 9, 763–763.	Europe	Desk research	Secondary and tertiary prevention	Child sexual abusers and Child Sexual Exploitation Offenders (this also includes individuals at risk of offending)	Multiple target groups	There are a substantial number of ethical and legal issues that have to be considered during the development, evaluation, and implementation of online health services for CSAs and CSEMOs. Nevertheless, web-based treatments in forensic mental health have a number of advantages including increased access to health care, cost-effectiveness, time-savings, positive opinions regarding the use of technology and increased fidelity. Accordingly, we argue in favor of the development of an internet-based cognitive behavioral program for child sexual offenders using the presented quality standards. Sophisticated evaluation studies will have to investigate if interventions delivered over the internet have the potential to reduce recidivism as a stand-alone treatment or if they have additional beneficial effects on treatment outcomes when used as an adjunct to conventional f2f treatments.
Wild, T.S.N., Müller, I., Fromberger, P., Jordan, K., Klein, L., & Müller, J. L. (2020). Prevention of Sexual Child Abuse: Preliminary Results From	Germany	Quantitative research aimed at	Tertiary prevention	Male perpetrators of CSA	Adults who have	Results indicate that offense-supportive attitudes, emotional distress, the use of CSEM, and

an Outpatient Therapy Program. *Frontiers in Psychiatry*, *11*, 88–88.		assessing impact of a treatment program			committed CSA	participants' subjective risk perception of committing (further) sexual offenses decreased significantly from pre- to post-intervention, and in the case of offense supportive attitudes also from pre-intervention to 1-year follow-up. The remaining measures of quality of life, self-efficacy, participants' self-perceived ability to control sexual impulses toward children and adolescents permanently, and the frequency of child and adolescent sexual abuse, and adolescent sexual exploitation material use did not reach a level of statistical significance, although in some instances, results indicate trends in the expected direction. During an average observation period of 2.4 years, six patients confessed to have conducted new sexual exploitation material offenses, while no further sexual abuse cases were reported (N = 19). Due to the used research design and small sample sizes, treatment effects cannot be inferred and external validity is limited. This notwithstanding, results provide first evidence for a relationship between treatment participation and self-reported recidivism and psychological well-being.

Wright, L. C., & Warner, A. (2020). EMDR treatment of childhood sexual abuse for a child molester: Self-reported changes in sexual arousal. *Journal of EMDR Practice and Research, 14*(2), 90–103	UK	Case study measuring changes in sexual arousal in child molester via EMDR treatment	Tertiary prevention	male perpetrator of CSA	Adults who have committed CSA	EMDR Effective in reducing any sexual arousal or attraction toward such children.

Annex 3 Programmes breakdown

Primary prevention			
Name of programme	**Country**	**Themes**	**Target group as described in source**
Chelsea's choice	UK	grooming and sexual exploitation (theatre play)	Young people aged 12 – 17
Expect Respect	UK	dating abuse and violence.	Children and young people in primary and secondary schools
Growing up with Jasmine and Tom	UK	sex and relationships	Teachers and Children aged 5-11
Hedgehogs	UK	child sexual exploitation/abuse	Children aged 9 to 11
Le Parole non Dette (Unspoken Words)	Italy	child sexual exploitation/abuse	Children aged 6-11
Looking for Lottie	UK	child sexual exploitation/abuse	Young people aged 14 years +
Offenders Beware	Italy, Germany, Austria, Estonia,Netherlands	child sexual tourism (training resources)	Professionals in the tourism industry
Safe Dates	Greece, Iceland, Ireland, The Netherlands, Switzerland, UK	dating abuse and violence.	Males and females aged 13-17
Social Connectivity Online Prevention and Experience (SCOPE)	UK	Safety and security online	Teachers and children aged 9-12

Stepping Stones	Estonia, Russia, Kyrgystan, France, Portugal	male perpetration of IPV and sexual risk leading to HIV/AIDS	Men and women of all ages
Teen Boundaries Sexual Bullying Programme	UK	Safety and security online	Children and teenagers aged 0-20
The 10-minute presentation	Belgium	Online CSA	Teenagers aged 10-13
Three Educational Packages	Finland	Safety and security online	Children aged 10-12

Secondary prevention

Name of programme	Country	Description	Type of programme	Target	Target as described in source
Anonymous	UK	Self-help website, email and helpline for adults at risk of CSA, family members	Self-help programme + helpline	Adults at risk of committing CSA + families	Adults at risk of child sexual offending, families, and communities
Aurora Project	UK	Community-based program combining group and individual sessions, using CBT and Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy (CFT) -Addressing risk and protective factors of sexual offending -medication to manage sexual arousal potentially accessible	Therapy (group and individual)	Adults at risk of committing CSA	Individuals who are concerned that they may sexually offend

Be Safe	UK	Be Safe Children's group programme for children aged 8 – 12 years (up to 14 for young people with learning disabilities) with worrying sexual behaviour and their parents/carers. 18 session cognitive behavioural therapy psycho- educational group programme provided over a 4 – 6 month period in one hour weekly group session, 7 of which are joint parent/care/child sessions .Includes the use of role play, puppets, storytelling and addresses what is appropriate sexual behaviour, sexual behaviour rules, safe boundaries, safety planning, keeping safe, sex education, parent training, impulse control, coping strategies, and child-parent relationships.	Therapy (group)	Children/youth at risk of committing CSA	Children aged 8 to 12 and up to 14 for those with learning disabilities with problematic sexual behaviour and their parents/carers
Beit Lynn	Israel	Specialised centre with multidisciplinary team - legal and therapeutic interventions for young people with problematic behaviours towards siblings	Therapy	Children/youth at risk of committing CSA	Young people with problematic sexual behaviours towards siblings under the age of 12; victims of SSA
Don't offend	Germany	Outpatient group therapy focusing on overcoming problems in connection with individuals' sexual preference. Topics include, in particular: · Working on problems of self-esteem · Strengthening of resources · Development of future perspectives · Taking responsibility for one's own behavior · Development of social and cognitive abilities necessary to avoid committing sexual offending · Strengthening of the motivation to be able to control one's behavior in the long run · Increasing the ability to control sexual impulses by better coping with emotions and problems · Recognition and mastery of risky situations · Improving interpersonal skills	Therapy (group)	individuals at risk of committing CSA	Individuals who have not committed an offline or online sexual offence against a child, but who are worried about doing so, as well as people who have already offended but have not come to the attention of the authorities.
Espace	Switzerland	Threshold service (mainly helpline)for children ana adults at risk of CSA	Helpline	Children/young people and adults at risk of committing CSA	Young people aged 12 years + and adults) worried by their own sexual attraction or thoughts concerning Children, but who have never acted upon these thoughts. This includes people who have viewed illegal

					images of children on the Internet, but have not offended offline. People worried by someone else's (young people aged 12 years + and adults) sexual attraction or thoughts concerning children (for example a partner or a friend) and that person has never acted upon these thoughts. Families/communities
G-map	UK	G-map adopts an individualised approach to treatment, informed by the Good Lives Model (which emphasises a strengths based approach) and by the principles of the Risk Needs Responsivity Model. A range of therapeutic approaches are used including cognitive behavioural therapy, compassionate mind training, dialectical behaviour therapy, experiential therapy, attachment focused treatment, resilience-based interventions and narrative therapy, in accordance with individual needs	Therapy (individual)	Children/youth at risk of committing CSA	Children and young people aged 6-18 years, who display problematic or harmful sexual behaviour; Their families
Help Wanted	international	Online self-help page and course for individuals at risk of CSA	Self-help programme	Individuals at risk of committing CSA	Individuals with sexual interest in prepubescent and early pubescent children
Inform Plus	UK	Programme for people under investigation for CSEM involving group or individual treatment. Psychoeducational, covering topics like offense analysis; the role of sexual fantasy in sexual offending; addictions and compulsions; disclosure, social skills, and relationships; criminal justice information; victim empathy; and lifestyle change and looking to the future. from responding empathically).	Therapy	Adults (males) at risk of committing CSA	Male users of CSEM who are under investigation

Inform YP (N.B. ALSO TERTIARY PREVENTION)	UK	Inform YP is not a comprehensive treatment programme for young people 13-21. It is a psycho-educational programme through which participants are provided with advice, information and support.	Support programme (not therapy)	Children/youth at risk of committing CSA	Children and young people aged approximately 13 to 21 years, with concerning sexual behaviour on the Internet.
New Direction (from which ReDirection is born)	Finland	16 weekly sessions attended in person or anonymously by potential offenders. These sessions are tailored to an individual's particular needs. 50-70 persons go through this programme yearly.The programme follows a three-part structure.Part A (sessions 1-3) Talking about what happened. Increasing motivation to work on yourself and to change.	Self-help programme	Individuals at risk of committing CSA	Adults worried about harmful sexual activity or fantasies.
Online Solicitation Program	UK	F2F program based on individual sessions and focusing on online solicitation and grooming	Therapy (individual)	Adults (males) at risk of committing CSA	Men who have used the internet to engage in sexual discussions with children and/or have engaged in discussions about meeting children offline
Prevent It!	Sweden	Anonymous internet-based cognitive behavioral therapy (CBT) intervention on CSAM. It contains weekly module content, assignments between modules, and weekly individual therapist feedback over eight weeks.	Self-help programme	Individuals at risk of committing CSA	Adults who currently access CSAM over onion sites
Prevent Tell	Sweden	Helpline for men and women at risk of committing sexual offences	Helpline	Individuals at risk of committing CSA	Men and women at risk of committing sexual offences
Prevention of sexual abuse (N.B. ALSO TERTIARY PREVENTION)	Germany	Prevention of Sexual Abuse" tries to fill this gap by providing treatment to patients with a self-reported sexual interest in children and adolescents, irrespective of whether or not they are pedophilic or prosecuted by the legal justice system. Within the project, a treatment manual was developed which specifically addresses dynamic risk-factors in child sexual abusers and CSEM offenders	Therapy	individuals at risk of committing CSA	Men and women who are concerned about their sexual fantasies and behaviors toward children and adolescents, irrespective of whether they have already committed an offense against the sexual self-determination of children. It is further irrelevant if clients fulfill the diagnostic criteria for pedophilia or are being prosecuted criminally.

Prevention project Dunkefeld	Germany	Community-based, weekly group sessions rooted in psychotherapy, sexology, medicine, psyhologt	Therapy (group)	Adults at risk of committing CSA	Individuals 18+ with 'pedophilic disorders' who are currently 'judicially inconspicuous'. Addressing both CSA and CSE online
Prevention project Dunkefeld Juveniles	Germany	Community-based, weekly group sessions rooted in psychotherapy, sexology, medicine, psychology.	Therapy (group)	Children/youth at risk of committing CSA	Individuals under 18 at risk of committing sexual abuse
ReDirection	Finland	The ReDirection Self-Help Program is based on the manualised UUSI SUUNTA Individual Program for Sex Offenders, based on CBT and guiding users to stop using CSAM.	Self-help program	Adults at risk of committing CSA	Potential CSAM offenders
Rosa	UK	A 6-8 week course of individual and/or family sessions for young people with potentially harmful online sexual behaviour . Groups for Parents and community members	Therapy (group and individual)	children/youth at risk of committing CSA	Children and young people aged between 8-18, who have potentially harmful online sexual behaviour.
SAA (N.B. ALSO TERTIARY PREVENTION)	UK	peer support for individuals suffering from sex addiction	Peer support (offline)	Individuals at risk of committing CSA	Adults who have a desire to stop their addictive sexual behaviour. Although many will want to recover from sexual behaviour which does not involve children or images of children, some will feel at risk of committing, child sexual abuse
Stop it Now! (N.B. ALSO TERTIARY PREVENTION)	UK	Online program and helpline for people at risk of CSA	Self-help programm e + helpline	Adults at risk of committing CSA + families	Individuals of all genders who are concerned about interest in children; Family members, friends
Stop So (N.B. ALSO TERTIARY PREVENTION)	UK	Therapy sessions for people at risk of CSA and their families (can be booked online)	Therapy	Adults at risk of committing CSA	Individuals who: are at risk of committing a sexual offence or are concerned about their behaviour, are sexually attracted to children but have not sexually offended against a child

Troubled Desire	Germany	Troubled Desire provides online assessment to receive feedback on their sexual preferences and problematic sexual behavior, and 16 self-directed treatment modules for individuals who self-identify and have a sexual interest in children. Participants can complete self-help modules at their own pace, and the modules are based on the material covered in the Dunkelfeld program	Self-help programme	Individuals at risk of committing CSA	Individuals who self-identify and have a sexual interest in children.
Turn the Page	UK	Turn the Page 'Change for Good' is a 26 session treatment programme for males aged 12 -18 years who display sexually harmful behaviors based on cognitive behavioural approach and draws on attachment theory, mentalisation theory and psychodynamic and systems theories. The 'Change for Good' programme runs for 30 weeks and has four modules: • Engagement module (four sessions) • Relationship module (nine sessions) • Self-regulation module (eight sessions) • Road map for future (five sessions)	Therapy	Children and youth (boys) at risk of committing CSA	Males aged 12 -18 years who display sexually harmful behaviour
Virtuous pedophilies	international (online)	Online peer support (forum) where individuals at risk of committing CSA can interact and exchange views and experiences.	Peer support (online)	Individuals at risk of committing CSA	Non-abusing adult pedophiles of all genders
Woodlands	UK	Residential support programme for boys between the ages of 11 and 18 with HSB who often present with complex needs including emotional, cognitive, psychological and social difficulties.	Therapy (residential)	Children and youth (boys) at risk of committing CSA	Boys between the ages of 11 and 18 with HSB

Tertiary prevention

Name of programme	Country	Description	Type of programme	Target group	Target group as described in source
Anonymous	Finland	Helpline for women using violence against partners or spouses linked to therapy. Individual and group sessions, psycho-dynamic-humanist concept of self	Helpline + therapy (group and individual)	Adults (females) who have committed CSA	Women who used family violence against their spouses or children
Assessment and Treatment Programme for Women who have Sexually Abused a Child/Children	UK	Prison-based programme from a gender informed perspective. Experience shows that workers who have an interest in and previous experience of working with women. Schema therapy, Dialectical Behaviour Therapy and research relating to trauma. Module one - exploration of the cognitions which underpin the participant's motivations for change, her offence patterns and	Therapy (prison-based)	Adults (females) who have committed CSA	Women with convictions relation to the sexual abuse of children.

		her attitudes to children. Module two on sexual and non-sexual relationships, victim empathy and the development of a New Life plan. Module three - focuses on personally relevant risk factors, self-management plans, goal setting and problem-focused solutions. The 'New Life' Manual is a self-help manual used by the participant, concurrently with the intervention programme agencies			
Breaking the Links	UK	Ten-week psychoeducational group-work programme. Pre and post evaluation measures are taken using the Justice Outcomes Star Chart tool. During the programme the participants are asked to complete a CORE-10 questionnaire which explores their current well-being including anxiety, depression, trauma, physical problems, functioning and risk to self.This programme is delivered in a group setting by two facilitators, with no more than six participants per group. Ten sessions are delivered, frequency of one session per week.	Therapy	Adults (males) who have committed CSA online and have a history of trauma	Adult, males who have been arrested for Internet related sexual offences but who also have experienced trauma themselves
BUP	Sweden	BUP offers various forms of treatment such as counselling, psycho-pedagogical interventions, drug treatment, group treatments, family-based interventions and psychological treatment, often with elements of behavioural training.	Therapy	Juveniles who have sexually offended	Children, both boys and girls, who are younger, between 3 and 17, who have acted in a sexual manner against other children.
CoSA	UK, NL, Belgium, Spain, Latvia, Bulgaria, Italy and Irelnd	Community-based programs relying on volunteers (outer and inner circles)	Support program (community-based)	Adult (males) who committed CSA	Former inmates convicted of a sexual offence
Glebe	UK	Glebe therapeutic community (TC) principles include communalism (living and working together), permissiveness – now called tolerance (difficult issues can be explored, though boundaries have to be set), reality confrontation (facing up to the impact of destructive behaviour) and democracy (how to	Therapy (residential)	Juveniles who have sexually offended	Youth who have sexually offended

		contribute to a consensus, and abiding by decisions taken). The approach is rooted in psychodynamic and trauma-informed practice			
Hope for Children and Families	UK	Hope for Children and Families is an evidence based resource pack for delivery to frontline practitioners who work with parents and carers whose children and young people responsible for harmful sexual behaviour.	Support programme	Parents and carers of juveniles who have sexually offended	Parents/carers of children who present sexually harmful behaviour
Inform Couples	UK	Inform couples is a programme for couples where one partner has been viewing illegal images of children or committing other sex offences online. The offending partner may have been convicted or may be awaiting the outcome of a police investigation or court case, but the person's online behaviour should be known to the authorities. It utilises a strengths-based theory and includes a 'New Life Plan' and relapse prevention strategies.	Therapy	Couples where one party has committed CSAM/ CSEM online	couples who are seeking to rebuild their relationship following arrest/conviction of a partner for sexual offences committed online.
Inform UK	UK	The aims is to provide information about all aspects of internet sexual offending against children and to offer support to partners, family members and friends of those arrested for or convicted of these offences.	Support programme	Partners and families	Wives, partners, adult family members and friends of adults who have been arrested, cautioned or convicted in connection with accessing indecent images of children on the internet.
Inform YP (N.B. ALSO SECONDARY PREVENTION)	UK	Inform YP is not a comprehensive treatment programme for young people 13-21. It is a psycho-educational programme through which participants are provided with advice, information and support.	Support programme	Juveniles who have sexually offended	Children and young people aged approximately 13 to 21 years with illegal sexual behaviour on the Internet.
Living as a new me	UK	Programme aimed at restructuring attitudes that support or permit sexual offending and (2) changing previous dysfunctional behaviours by building new skills and resources.	Therapy	Adults (males) who have committed CSA	Men aged 18 or over who have been convicted of a contact sexual offence against a child.

PAS I and II	Switzerland	Short-term CBT intervention for JSOs (treatment duration, approx. 4–9 months). The programme can be used for individuals or small groups of 2–6 participants. Additionally, it can be combined with further psychotherapeutic or medical treatments of (nonsexual) comorbid psychiatric disorders (e.g., attention-deficit-hyperactivity disorder and affective disorders).The PaS-I and ThePaS-II comprise 19 and 20 modules. Ten modules (e.g., introduction, juvenile justice system, criminal articles for sexual offenses, sexuality, emotion perception, socially adequate flirting, building relationships, awareness of individual goals and resources) comparable . Among the specific modules of the ThePaS-I, three modules focus on understanding previous sexual offenses, three modules focus on building individual offense prevention plans, and one module addresses victim empathy. For ThePaS-II, two modules address problem solving, two modules address body sensations and mindfulness training, and some further modules addressed self-control, "saying no," and moral judgment.	Therapy	Juveniles who have sexually offended	Juveniles who have sexually offended
Prevention of sexual abuse (N.B. ALSO SECONDARY PREVENTION)	Germany	Programme for CSAs and CSEMOs	Therapy	Adults who have committed CSA	Offenders with probation conditions can commence treatment
Restorative Approaches to Sexually Harmful Behaviour	UK	Programme with a focus on: A previous close or familial relationship which will endure beyond the harm that has arisen, but which needs to be placed on a safe and managed footing · Questions and issues that the victim needs to be addressed and which were ignored by the formal criminal justice processes · The need to address the reality of the harm caused in a context which is wider and more inclusive than that offered through the formal criminal justice process · To offer benefit to the healing and recovery process which many victims seek and/or offering additional dimensions to victim empathy and the expressions of shame and remorse by the offender	Therapy	Juveniles who have sexually offended	Children and young people who display sexually harmful behaviour (SHB) and victims of children and young people who display SHB
Rolling Sex offender Treatment Program	UK	Rolling group program on the following topics: Introduction · Life Description · Identifying factors that contributed to your offending · Risk factors and warning signs · Protective factors	Therapy (group)	Adult (males) who have committed CSA	Adult male sex offenders, including

		and goals · Self-Management Compulsory Group + assignments			those who have committed CSA
SAA (N.B. ALSO SECONDARY PREVENTION)	UK	Peer support for individuals suffering from sex addiction	Peer support (offline)	Adults who have committed CSA	Adults who have been convicted of or committed child sexual abuse
Securus	UK	e-Safety software, which examines personal home computers of sex offenders for specific inappropriate words and phrases and images	Software	Adults who have committed CSA online	Arrested and convicted Internet sex offenders
SEIF	Sweden	Inspired by RNR and by Acceptance and Commitment Therapy, added to the CBT methods. The initial phase of the programme consists of information gathering, followed by an individualized treatment plan with risk-reducing treatment goals for the client.The second phase is guided by the clients treatment plan, and consists of four themes based on dynamic risk factors for sexual recidivism; Emotions, Sexuality, Attitudes and Relationships.The ending phase aims to develop a plan for the future.	Therapy	Adults who have committed CSA	adults convicted of sexual offences including CSA
SeNat	Lithuania	SeNat is a prison-focused program based on CBT. Group topics include the discussion of Autobiographies, offence Patterns, self-Control, relapse Prevention Plans, life Plans	Therapy (group; prison-based)	Adults who have committed CSA	Incarcerated persons who have committed sexual offences against children
Sex Offender Control Program	Spain	This treatment program is group based and is used to treat those who have committed sex offenses against women and children. In general, the program lasts from one to two years and is delivered twice weekly in two-and-a-half-hour sessions. The applied treatment focuses on the following intervention ingredients: (a) relaxation training; (b) analysis of history and personal development of each subject; (c) restructuring of cognitive distortions and justification of crime; (d) emotional regulation; (e) prevention of violent behavior; (f) coping techniques; (g) empathy with victims; (h) training for a positive way of life; (i) sex and health education; (j) changing sexual impulses, and (k) relapse prevention.	Therapy (group)	Adults who have committed CSA	adults convicted of sexual crimes including CSA
Stop it Now! (N.B. ALSO SECONDARY PREVENTION)	UK	Online program and helpline for people at risk of CSA	Self-help program + helpline	Adults who committed CSA and their families/friends	Individuals who have committed CSA; their family members, friends

Stop So (N.B. ALSO SECONDARY PREVENTION)	UK	therapy sessions for people who committed CSA and their families (can be booked online)	Therapy	Adults who committed CSA and their families	Individuals who are in prison, are partners or other family members of any of the above individuals
The Challenge Project	UK	Slow open program of 15 months covering offence disclosure, victim empathy, self as victim, sexual assault cycle, relationships and introduction to relapse prevention. However, there is an emphasis on personal histories, attachment difficulties and developmental trauma,	Therapy	Adult (males) who have committed CSA with severe mental health issues	Men aged 18 years and over with a conviction for a contact sexual offence against adults or children, who are not able to participate in mainstream sex offender treatment programmes due to mental health needs
The Ma'agalim Centre	Israel	A residential hostel and a day centre providing community-based programmes for adult sex offenders and maintenance groups to maintain learning following treatment completion. Anti-libidinal medication to reduce their sex drive provided. CBT and some psychoeducational aspects. Treatment in group and sometimes individual. Topics include identifying and analysing the offence-chain, sex education, communication, role play and cognitive restructuring, anger management, assertiveness and life-skills training, defensiveness reduction, relapse prevention, victim empathy education and reducing the offender's denial/minimisation	Therapy (residential/community-based)	Adults (males) who committed CSA	Adult male sex offenders including those who have committed CSA
The Thames Valley Sex Offenders Program	UK	Group based treatment approach for eight to 10 adult male sexual offenders, in community settings; CBT and RNR	Therapy (group)	Adults who committed CSA	Sex offenders against children and/or adults, as well as those who have committed non-contact sexual offences.
Youth probation services	Israel	CBT residential program based on model of sexual offense cycle, which includes elements of relapse prevention interventions. Based on a multisystemic perspective, the probation officer supervises the process and addresses other aspects of the juveniles' lives: school, peer group, leisure time activities, family relationships, etc. Group therapy and cooperation with parents	Therapy (residential)	Juveniles who have sexually offended	Juveniles between 12 and 18 who have sexually offended

Youth probation services 2	Israel	Psycho-educational and supportive groups for parents within a framework of 14 bi-weekly 90-minute meetings drawing on a systemic, socio-ecological approach and a social learning theory perspective.	Therapy (group)	Parents and carers of juveniles who have sexually offended	Parents of juveniles who have sexually offended
@ my tabu	Germany	This web-based intervention comprises six modules: motivation, supervision, emotions management, problem-solving, offense-supportive attitudes, sexuality. All web-based intervention modules comprise techniques of motivational interviewing, psycho-educational modules, online training, and tasks in order to learn and practice new ways of thinking and coping. Possibility to access support of an online coach.	Support program	Adults who have committed CSA	Male and female adult CSA and CSE offenders under community supervision

Annex 4 Questionnaire templates

Perpetrator programmes in Europe

Introduction

The European Network for Work With Perpetrators (WWP EN) is currently working on a mapping of perpetrator programmes in Europe to gain a better understanding of the current practices and the challenges perpetrator programmes are facing on the ground. This is crucial for WWP EN to be able to initiate changes, advocate, and work to ensure that perpetrator programmes across Europe are able to work efficiently, and have the support they need. This mapping is done in collaboration with the Council of Europe. If you work with perpetrators of any type of violence (general violent offenders, domestic violence offenders, sexual offenders and/or child sexual offenders) we would like to ask your organisation to answer a short survey to help us gain knowledge on the main practices and approaches that exist when working with this population.

Important notes

It should take you around 10-30 minutes to fill out the questionnaire (depending on your answers your survey can be shorter or longer). We really appreciate your time investment. If you do not work with this type of offenders but know another organisation that it is, please feel free to forward them this email. All the information you share with us will be anonymized (only information about countries will be shown). Results from this mapping will be published in a report of the Council of Europe and an Expert paper of WWP EN..

Structure

The questionnaire is divided into 8 Sections: A. Basic information; B.Gender-informed approaches to perpetrator work; C. Work with sexual offenders (generic section) ; D.Work with Child Sexual abusers - Primary prevention; E. Work with Child Sexual abusers - Secondary prevention; F. Work with Child Sexual abusers - Tertiary prevention; G. Victim support; H. Quality assurance and evaluation. Depending on your answers, you may not be required to answer questions in all sections. The questionnaire is designed to skip questions that are not relevant to your work.

Definitions

"Work", "model" and "program":

"Specific work with adult male and/or female perpetrators of child sexual abuse" or with "minors who have committed child sexual abuse". If something else is meant, this will be explicitly defined. The terms "participant" and "client" mean both participants of group work and clients of face to face work.

Sexual violence:

The term "sexual violence" is an all-encompassing, non-legal term that refers to crimes like sexual assault, rape, incest. Please note that the legal definition of crimes vary across countries and states (RAINN, n.d.)

Child sexual abuse:

Sexual abuse and sexual exploitation of children can take multiple forms and can occur both online (e.g. forcing a child to engage in sexual activities via live streaming or exchanging child sexual abuse material online) and offline (e.g. engaging in sexual activities with a child or causing a child to participate in child prostitution). When the abuse is also recorded and shared online, the harm is perpetuated (EU Strategy for a more effective fight against child sexual abuse, 2020).

Primary prevention:

Is aimed at the general population and seeks to address risk factors for crime

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Secondary prevention:

Engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime

---

Tertiary prevention:

Deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences

Victim/survivor:

Person who received/suffered the abusive / violent behaviour. This term is used as in many countries the term "victim" is more common and comprehensive but, at the same time, it is important to emphasise the term "survivor" which reflects the empowering aspect of the experience of surviving violence.

» A. Basic information

Name of the organisation

Name and surname of person completing the questionnaire

Role in the organization

Years working for the organization

- ◯ <1
- ◯ 1-3
- ◯ 4-6
- ◯ >6

Email address

Is your organisation a member of :

- ◯ CEP
- ◯ WWP
- ◯ Other
- ◯ No network

If other, please specify

Country

Please provide a brief description of your organization

Please provide a link to your organization's website

Size of the organization

- ( ) Micro (up to 10 employees)
- ( ) Small (11-50 employees)
- ( ) Medium (51-100 employees)
- ( ) Large (100 + employees)

What is the context of your work? (please select all relevant options)

- [ ] Prison
- [ ] Probation
- [ ] Alternatives to imprisonment
- [ ] Community
- [ ] Other

If you selected other, please specify

Do you work with? (please select all relevant options)

- [ ] Domestic violence / gender-based violence offenders
- [ ] Sexual offenders targeting adults
- [ ] General violent offenders
- [ ] Child abuse offenders
- [ ] Minors using violence

B.Gender-informed approaches to perpetrator work

Do you think that it is important to apply a gender approach to the treatment of offenders (any type of offenders)?

- ◯ Yes
- ◯ No
- ◯ Not sure

Do you apply a gender approach to the treatment of offenders?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe briefly how you to apply a gender approach to the treatment of offenders

_____

Do you apply a gender approach to the treatment of domestic violence / gender-based violence offenders?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe briefly how you to apply a gender approach to the treatment of gender-based violence offenders

_____

C. Work with sexual offenders (generic section)

Which service users does your organization work with? (please select all relevant options)

- ☐ Male sexual offenders (adults)
- ☐ Female sexual offenders (adults)
- ☐ Adult males at risk of committing sexual abuse
- ☐ Adult females at risk of committing sexual abuse
- ☐ Juvenile males who have committed a sexual offence
- ☐ Juvenile females who have committed a sexual offence
- ☐ Underage males at risk of committing sexual abuse
- ☐ Underage females at risk of committing sexual abuse
- ☐ Adult community members for primary prevention purposes
- ☐ Minors community members for primary prevention purposes
- ☐ Family members/relatives of any of the above

In its work on sexual abuse does your organisation focus on:

- [ ] Primary prevention - Is aimed at the general population and seeks to address risk factors for crime
- [ ] Secondary prevention - Engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime
- [ ] Tertiary prevention - Deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences

If you work with female sexual offenders, do you use a specific approach for this target group?

- ( ) Yes
- ( ) No
- ( ) Not sure
- ( ) N/A don't work with female sexual offenders

If yes, please specify

_____

If you work with migrant sexual offenders, do you use a specific approach for this target group?

- ( ) Yes
- ( ) No
- ( ) Not sure
- ( ) N/A don't work with migrant sexual offenders

If yes, please specify

_____

Do you use a specific treatment model in your work with sexual offenders?

- ( ) Yes
- ( ) No

If yes, please provide further details (e.g. RNR, Good Lives, a combination of different models)

_____

What kind of professionals are involved in delivering programs focusing on sexual abuse (please select all relevant options)

- [ ] Social workers
- [ ] Psychotherapists
- [ ] Psychologists
- [ ] Mental health workers
- [ ] Educators
- [ ] Sexologists/ sexuality educators
- [ ] Former clients
- [ ] Other

If you selected other, please specify

Do you use risk assessment instruments?

- ◯ Yes
- ◯ No

For every target group which you have indicated to work with, please specify the specific type of risk assessment instrument utilised. You can group target groups if needed (e.g. TG: At-risk male adults/adult male sexual offenders: name of risk assessment)

How often/at which stages do you conduct risk assessments?

- ◯ At intake phase/ immediately after
- ◯ At intake phase/immediately after, halfway through the program, at the end of the program
- ◯ At intake phase/ immediately after and at the end of the program
- ◯ Other

If you selected other, please specify

Does your organisation offer?

- ◯ General treatment/ therapeutic interventions for sex offenders, including child sexual offenders
- ◯ Specific treatment/ therapeutic interventions for child sexual offenders

Do you provide individual or group sessions for sexual offenders? (please select all relevant options)

- ☐ Individual
- ☐ Group

Do you run (please select all relevant options)?

- ☐ Adult male only groups
- ☐ Adult female only groups
- ☐ Adult same sex groups
- ☐ Groups for male minors
- ☐ Groups for female minors
- ☐ Groups for parents/relatives
- ☐ Other

What are the main topics/modules addressed in groups for sexual offenders? Please distinguish between the contents of different groups selected, if necessary and relevant

---

What challenges or needs do you face in your work present and future? (please select all relevant options)

- [ ] Lack of evidence-based programmes for sexual offenders
- [ ] Lack of specific competencies of staff
- [ ] Lack of human resources to conduct rehabilitation activities
- [ ] Lack of post-penal support in the community
- [ ] Lack of funding

D. Work with Child Sexual abusers - Primary prevention

Primary prevention is aimed at the general population and seeks to address risk factors for crime.

In which setting does your organization roll out primary prevention programs? (e.g. schools, other community settings)

Who are the main beneficiaries of these programs? (Please select all relevant options)

- [ ] Male adults
- [ ] Female adults
- [ ] Male minors
- [ ] Female minors

What is the frequency of programs?

- ◯ One-off
- ◯ Regular

If you selected regular, please provide further details on frequency

---

What are the topics/contents of your primary prevention programs?

How long have you been running these programs for?

- ◯ <1 year
- ◯ 1-3 years
- ◯ >3 years
- ◯ >5 years

How many professionals are involved in delivering these programs?

- ◯ 1-2
- ◯ 3-5
- ◯ >5

E. Work with Child Sexual abusers - Secondary prevention

Secondary crime prevention engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime

In which setting does your organization offer secondary prevention programs? (e.g. own premises; through helpline; on premises of other organisation it collaborates with - please specify which organisation and how the collaboration works)

Who are the main beneficiaries of programs? (Please select all relevant options)

- [ ] Male adults at risk of committing child sexual abuse
- [ ] Female adults at risk of committing child sexual abuse
- [ ] Male minors at risk of committing child sexual abuse
- [ ] Female minors at risk of committing child sexual abuse
- [ ] Male adults awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Female adults awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Male minors awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Female minors awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Parents/guardians of minors at risk of child sexual abuse / awaiting cj outcomes
- [ ] Family members of individuals at risk of child sexual abuse/awaiting cj outcomes
- [ ] Other

If you selected other, please specify

How do service users access programs? (please select all relevant options)

- [ ] Self-referrals/ referrals by family members
- [ ] Referral by police
- [ ] Referral by courts
- [ ] Referral by social and welfare agencies
- [ ] Referral by victim services
- [ ] Referral by child protection services
- [ ] Referral by alcohol and substance abuse treatment service
- [ ] Other

If you selected other, please specify

What are the minimum requirements to access programs?(please select all relevant options)

- [ ] Age
- [ ] Signing an agreement / contract as basis for program participation
- [ ] Demonstrating a minimum motivation to participate
- [ ] Cognitive ability to follow the program
- [ ] Good enough knowledge of language
- [ ] Fulfilling the facilitator's requirements for group work (if group work is conducted)
- [ ] Lack of addiction to alcohol or drugs
- [ ] Lack of severe mental disorders
- [ ] Degree of limited confidentiality (e.g. against victim/survivor, referring institutions)
- [ ] Other

If you selected other, please specify

_____

If you selected age, please specify minimum age (N.B. If you run programs for both adults and minors, please specify different age requirements for each)

_____

Intake/assessment phase

- ◯ No intake / clearing phase
- ◯ Only initial interview
- ◯ Individual counselling phase before group work

Are programs rolled out in group settings or 1-1(please select all relevant options)?

- [ ] 1-1
- [ ] Group

What are your facilitation arrangements for 1-1 sessions?

- ◯ 1 male facilitator
- ◯ 1 female facilitator
- ◯ Male team
- ◯ Female team
- ◯ Mixed team

What are your facilitation arrangements for group sessions?

- 1 male facilitator
- 1 female facilitator
- Male team
- Female team
- Mixed team

If there are any substantial differences in facilitation arrangements between programs for different service users, please specify them here

_____

If you selected team above, please indicate the number of facilitators

- 2
- 3-4
- >4

Frequency of 1-1 sessions

- 1-1
- Group

Frequency of group sessions

- Weekly
- Twice a week
- Fortnightly

If there are any substantial differences in frequency between programs for different service users, please specify them here

_____

Duration of 1-1 sessions (in minutes) - please distinguish between different service users, if applicable

_____

Duration of group sessions (in minutes) - please distinguish between different service users, if applicable

_____

What is the duration of 1-1 programs?

- up to 3 months
- up to 6 months
- up to 1 year
- 1-2 years
- No time limitation

What is the duration of group programs?

- ( ) up to 3 months
- ( ) up to 6 months
- ( ) up to 1 year
- ( ) 1-2 years
- ( ) No time limitation

What is the framework of group work?

- ( ) Open (rolling) groups
- ( ) Closed groups
- ( ) Both

If you selected 'both', please elaborate

_____

If there are any substantial differences in group frameworks in groups for different service users, please specify them here

_____

Average number of group participants

- ( ) 2-5
- ( ) 6-10
- ( ) >10

If there are any substantial differences in average number of group participants in groups for different service users, please specify them here

_____

Do you run (please select all relevant options)

- [ ] Adult male only groups
- [ ] Adult female only groups
- [ ] Adult same sex groups
- [ ] Groups for male minors
- [ ] Groups for female minors
- [ ] Groups for parents/relatives
- [ ] Other

If you selected other, please specify

_____

What are the main topics/modules addressed in the groups? Please distinguish between the contents of different groups selected, if necessary and relevant

_____

If you have any additional comments to add to this section on secondary prevention work, please do so here

F. Work with Child Sexual abusers - Tertiary prevention

Tertiary crime prevention deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences

In which setting does your organization offer tertiary prevention programs?

- [ ] Prison
- [ ] Community
- [ ] Other

If you selected other, please specify

Who are the main beneficiaries of such programs ? (please select all relevant options)

- [ ] Adult male inmates
- [ ] Adult female inmates
- [ ] Former adult male inmates
- [ ] Former adult female inmates
- [ ] Adult males on probation
- [ ] Adult females on probation
- [ ] Male minors who committed child sexual abuse
- [ ] Family members/relatives of adult inmates (male or female)
- [ ] Parents of minors who committed chilse

How do service users access programs? (please select all relevant options)

- [ ] Referral by police
- [ ] Referral by professionals working in prison
- [ ] Referral by courts
- [ ] Referral by social and welfare agencies
- [ ] Referral by victim services
- [ ] Referral by child protection services
- [ ] Referral by alcohol and substance abuse treatment service
- [ ] Referral by probation
- [ ] Other

If you selected other, please specify

What are the minimum requirements to access programs?(please select all relevant options)

- [ ] Age
- [ ] Signing an agreement / contract as basis for program participation
- [ ] Demonstrating a minimum motivation to participate
- [ ] Cognitive ability to follow the program
- [ ] Good enough knowledge of language
- [ ] Fulfilling the facilitator's requirements for group work (if group work is conducted)
- [ ] Lack of addiction to alcohol or drugs
- [ ] Lack of severe mental disorders
- [ ] Degree of limited confidentiality (e.g. against victim/survivor, referring institutions)
- [ ] Other

If you selected other, please specify

_____

If you selected age, please specify minimum age (NB. If you run programs for both adults and minors, please specify different age requirements for each).

_____

Intake/assessment phase

- ◯ No intake / clearing phase
- ◯ Only initial interview
- ◯ Individual counselling phase before group work

Are programs rolled out in group settings or 1-1(please select all relevant options)?

- [ ] 1-1
- [ ] Group

What are your facilitation arrangements for 1-1 sessions?

- ◯ 1 male facilitator
- ◯ 1 female facilitator
- ◯ Male team
- ◯ Female team
- ◯ Mixed team

What are your facilitation arrangements for group sessions?

- 1 male facilitator
- 1 female facilitator
- Male team
- Female team
- Mixed team

If there are any substantial differences in facilitation arrangements between programs for different service users, please specify them here

_____

If you selected team above, please indicate the number of facilitators

- 2
- 3-4
- >4

Frequency of 1-1 sessions

- 1-1
- Group

Frequency of group sessions

- Weekly
- Twice a week
- Fortnightly

If there are any substantial differences in frequency between programs for different service users, please specify them here

_____

Duration of 1-1 sessions (in minutes) - please distinguish between different service users, if applicable

_____

Duration of group sessions (in minutes) - please distinguish between different service users, if applicable

_____

What is the duration of 1-1 programs?

- up to 3 months
- up to 6 months
- up to 1 year
- 1-2 years
- No time limitation

What is the duration of group programs?

- ( ) up to 3 months
- ( ) up to 6 months
- ( ) up to 1 year
- ( ) 1-2 years
- ( ) No time limitation

What is the framework of group work?

- ( ) Open (rolling) groups
- ( ) Closed groups
- ( ) Both

If you selected 'both', please elaborate

_____

If there are any substantial differences in group frameworks in groups for different service users, please specify them here

_____

Average number of group participants

- ( ) 2-5
- ( ) 6-10
- ( ) >10

If there are any substantial differences in average number of group participants in groups for different service users, please specify them here

_____

Do you run (please select all relevant options)

- [ ] Adult male only groups
- [ ] Adult female only groups
- [ ] Adult same sex groups
- [ ] Groups for male minors
- [ ] Groups for female minors
- [ ] Groups for parents/relatives
- [ ] Other

If you selected other, please specify

_____

What are the main topics/modules addressed in the groups? Please distinguish between the contents of different groups selected, if necessary and relevant

_____

If you have any additional comments to add to this section on tertiary prevention work, please do so here

---

G. Victim Support

Is victim support provided during your programs (for secondary and tertiary prevention)?

- ◯ Yes
- ◯ No

If you answered yes, how is victim support provided? (please select all relevant options)

- ☐ By my organization, a specific unit/professional that works just with victims
- ☐ By my organization, by the facilitator/s of the perpetrator program
- ☐ Through partnership with external organization/s that work/s with victims

When is the victim/survivor contacted? (please select all relevant options)

- ☐ When the service user begins the program
- ☐ In the course of program implementation
- ☐ At the end of program

What is the purpose of the contact with victim/survivor? (please select all relevant options)

- ☐ Information about the program and its contents
- ☐ Information about specific working methods
- ☐ Information about limitations of the program (no guarantee for non-violence)
- ☐ Information about legal options
- ☐ Information about the importance of safety measures
- ☐ Information about specific victim services (e.g. victim's support services, shelters, services for refugees or migrants, counselling services for victims etc.)
- ☐ Partner (victim/survivor) experience of violence (their view on violent acts)
- ☐ Partner (victim/survivor) emotional support
- ☐ Assessment of the risk of violence and safety planning
- ☐ Evaluation of the program
- ☐ Other

If other, please specify

Is the victim/survivor informed in crisis situations and warned about risks?

- ◯ Yes
- ◯ No

How is the coordination with the victim support service/units/professionals managed?(please select all relevant options)

- [ ] Joint planning and decision making
- [ ] Case-oriented exchange of information: regularly
- [ ] Case-oriented exchange of information: if required
- [ ] No coordination
- [ ] Other

If other, please specify

_____

What information is exchanged with the support service/unit/professional?(please select all relevant options)

- [ ] Repeated abuse by client
- [ ] History of violence
- [ ] Information about risk
- [ ] High-risk situation
- [ ] No information is exchanged

In cases where victim/survivor is still a minor, which specific approaches, different from/additional to the ones detailed above, do you use?

_____

If you have any additional comments to add to this section on victim support, please do so here

_____

H. Quality Assurance/Documentation/Evaluation

Which of the following measures of quality assurance do you have? (select all relevant options)

- [ ] Team sessions
- [ ] Supervision
- [ ] Continuing education of staff
- [ ] None of the above
- [ ] Other

If other, please specify

_____

What documentation and reporting system do you have? (please select all relevant options)

- [ ] Standardized documentation of clients' demographic data
- [ ] Case-oriented, standardized documentation of work
- [ ] Case-oriented, non-standardized documentation of work (notes etc.)
- [ ] Annual activity report
- [ ] Annual statistics
- [ ] Other
- [ ] None

If other, please specify

_____

Do you measure the outcome of your work?

- ◯ Yes
- ◯ No

If you selected yes, at which stage? (please select all relevant options)

- [ ] When client finishes the program
- [ ] At first follow-up, after finishing the program
- [ ] At second follow-up, after finishing the program
- [ ] Other

If you selected at first follow-up, please indicate number of months:

_____

If you selected at second follow-up, please indicate number of months:

_____

What outcome do you measure for child sexual abuse? (please select all relevant options)

- [ ] Service user's self-assessment by interview
- [ ] Service user's self-assessment by questionnaire
- [ ] Facilitator's assessment of client by psychological inventory
- [ ] Facilitator's assessment of client by other questionnaire
- [ ] Facilitator's assessment of client using internal documentation and minutes
- [ ] Victim/survivor's assessment by interview
- [ ] Victim/survivor's assessment by questionnaire or inventory
- [ ] Assessment involving family members
- [ ] Official reports (police, court etc.)
- [ ] Other

If other, please specify

If you measure outcome in relation to victims/survivors who are still minors, which instruments do you use that are different from/additional to the ones detailed above?

If you have any additional comments to add to this section on quality assurance/documentation/evaluation, please do so here

---

Is there anything else that you'd like to add?

Thank you for completing this questionnaire!

Programs for child sexual offenders in Europe

Introduction

European Network for the Work with Perpetrators of Domestic Violence-WWP EN is conducting a mapping exercise to identify programs for perpetrators of child sexual abuse across the European region. The goal is to gather information concerning the set-up, objectives and modus operandi of these programs. The information gathered via this questionnaire will feed into a research report.

Important notes

It will take you approximately 25-30 minutes to complete the questionnaire.

Structure

The questionnaire is divided into 7 Sections: A. Basic information B. General practices C. Primary prevention D. Secondary prevention E. Tertiary prevention F. Victim support G. Quality assurance and evaluation. Depending on your answers, you may not be required to answer questions in all sections. The questionnaire is designed to skip questions that are not relevant to your work.

Definitions

"Work", "model" and "program":

"Specific work with adult male and/or female perpetrators of child sexual abuse" or with "minors who have committed child sexual abuse". If something else is meant, this will be explicitly defined. The terms "participant" and "client" mean both participants of group work and clients of face to face work.

Primary prevention:

Is aimed at the general population and seeks to address risk factors for crime

---

Secondary prevention:

Engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime

---

Tertiary prevention:

Deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences

---

Child sexual abuse:

Sexual abuse and sexual exploitation of children can take multiple forms and can occur both online (e.g. forcing a child to engage in sexual activities via live streaming or exchanging child sexual abuse material online) and offline (e.g. engaging in sexual activities with a child or causing a child to participate in child prostitution). When the abuse is also recorded and shared online, the harm is perpetuated (EU Strategy for a more effective fight against child sexual abuse, 2020).

Victim/survivor:

Person who received/suffered the abusive / violent behaviour. This term is used as in many countries the term "victim" is more common and comprehensive but, at the same time, it is important to emphasise the term "survivor" which reflects the empowering aspect of the experience of surviving violence.

» A. Basic information

Name of the organisation

Name and surname of person completing the questionnaire

Role in the organization

Years working for the organization

- ◯ <1
- ◯ 1-3
- ◯ 4-6
- ◯ >6

Email address

Is your organisation a member of WWP EN?

- ◯ Yes
- ◯ No

Country

Please provide a brief description of your organization

Please provide a link to your organization's website

Size of the organization

- Micro (up to 10 employees)
- Small (11-50 employees)
- Medium (51-100 employees)
- Large (100 + employees)

B. General practices

In its work with child sexual offenders, does your organisation focus on ? (please select all relevant options)

- [ ] Primary prevention (Primary prevention is aimed at the general population and seeks to address risk factors for crime)
- [ ] Secondary prevention (Secondary crime prevention engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime)
- [ ] Tertiary prevention (Tertiary crime prevention deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences)

Does your organisation offer?

- ◯ General treatment/ therapeutic interventions for sex offenders, including child sexual offenders
- ◯ Specific treatment/ therapeutic interventions for child sexual offenders

Which service users does your organization work with? (please select all relevant options)

- [ ] Male child sexual offenders (adults)
- [ ] Female child sexual offenders (adults)
- [ ] Male minors who have committed child sexual abuse
- [ ] Female minors who have committed child sexual abuse
- [ ] Adult males at risk of committing child sexual abuse
- [ ] Adult females at risk of committing child sexual abuse
- [ ] Male minors at risk of committing sexual abuse against other minors (e.g. exhibiting harmful behaviours)
- [ ] Female minors at risk of committing sexual abuse against other minors (e.g. exhibiting harmful behaviours)
- [ ] Family members/relatives of any of the above
- [ ] Adult community members for primary prevention purposes
- [ ] Minors community members for primary prevention purposes

For each target group selected above, please specify for how long you have been running programs

_____

Do you apply a gender approach to work with child sexual offenders?

- ◯ Yes
- ◯ No
- ◯ Not sure

If you answered yes, please describe briefly how you apply a gender approach to work with child sexual offenders

_____

Do you work according to some established concepts or a specific model in individual or group counselling?

- ◯ Yes
- ◯ No

If yes, please specify

_____

If you work with female child sexual offenders, do you use a specific approach for this target group?

- ◯ Yes
- ◯ No
- ◯ Not sure

If yes, please specify

_____

If you work with young people who committed child sexual abuse, do you use a specific approach for this target group?

- Yes
- No
- Not sure

If you answered yes, please specify

_____

If you work with migrant child sexual offenders, do you use a specific approach for this target group?

- Yes
- No
- Not sure
- N/A don't work with migrant child sexual offenders

If you answered yes to the above, please specify

_____

What kind of professionals are involved in delivering programs focusing on child sexual abuse (please select all relevant options)

- [ ] Social workers
- [ ] Psychotherapists
- [ ] Psychologists
- [ ] Mental health workers
- [ ] Educators
- [ ] Sexologists/ sexuality educators
- [ ] Former clients
- [ ] Other

If you selected other, please specify

_____

Do you use risk assessment instruments?

- Yes
- No

Please select all the target groups for which you use a specific risk assessment instrument (Please select all relevant options)

- [ ] Male adults at risk of committing child sexual abuse
- [ ] Female adults at risk of committing child sexual abuse
- [ ] Male minors at risk of committing child sexual abuse
- [ ] Female minors at risk of committing child sexual abuse
- [ ] Adult male child sexual offenders
- [ ] Adult female child sexual offenders
- [ ] Male minors who have committed a child sexual offence
- [ ] Female minors who have committed a child sexual offence

For every target group listed above for which you have indicated the use of a risk assessment instrument, please specify the specific type of risk assessment instrument utilised. You can group target groups if needed (e.g. TG: At-risk male adults/adult male child sexual offenders: name of risk assessment)

_____

How often/at which stages do you conduct risk assessments?

- ( ) At intake phase/ immediately after
- ( ) At intake phase/immediately after, halfway through the program, at the end of the program
- ( ) At intake phase/ immediately after and at the end of the program
- ( ) Other

If you selected other, please specify

_____

What challenges or needs do you face in your work present and future? (please select all relevant options)

- [ ] Lack of evidence-based programmes for child sexual offenders
- [ ] Lack of specific competencies of staff
- [ ] Lack of human resources to conduct rehabilitation activities
- [ ] Lack of post-penal support in the community
- [ ] Lack of funding

C. Primary prevention

Primary prevention is aimed at the general population and seeks to address risk factors for crime.

_____

In which setting does your organization roll out primary prevention programs? (e.g. schools, other community settings)

_____

Who are the main beneficiaries of these programs? (Please select all relevant options)

- [ ] Male adults
- [ ] Female adults
- [ ] Male minors
- [ ] Female minors

What is the frequency of programs?

- ( ) One-off
- ( ) Regular

If you selected regular, please provide further details on frequency

_____

What are the topics/contents of your primary prevention programs?

_____

How long have you been running these programs for?

- ( ) <1 year
- ( ) 1-3 years
- ( ) >3 years
- ( ) >5 years

How many professionals are involved in delivering these programs?

- ( ) 1-2
- ( ) 3-5
- ( ) >5

D. Secondary prevention

Secondary crime prevention engages in early identification of potential offenders and seeks to intervene in their lives in such a way that they never commit crime

_____

In which setting does your organization offer secondary prevention programs? (e.g. own premises; through helpline; on premises of other organisation it collaborates with - please specify which organisation and how the collaboration works)

_____

Who are the main beneficiaries of programs? (Please select all relevant options)

- [ ] Male adults at risk of committing child sexual abuse
- [ ] Female adults at risk of committing child sexual abuse
- [ ] Male minors at risk of committing child sexual abuse
- [ ] Female minors at risk of committing child sexual abuse
- [ ] Male adults awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Female adults awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Male minors awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Female minors awaiting criminal justice outcomes for child sexual abuse (post-arrest and pre-conviction)
- [ ] Parents/guardians of minors at risk of child sexual abuse / awaiting cj outcomes
- [ ] Family members of individuals at risk of child sexual abuse/awaiting cj outcomes
- [ ] Other

If you selected other, please specify

How do service users access programs? (please select all relevant options)

- [ ] Self-referrals/ referrals by family members
- [ ] Referral by police
- [ ] Referral by courts
- [ ] Referral by social and welfare agencies
- [ ] Referral by victim services
- [ ] Referral by child protection services
- [ ] Referral by alcohol and substance abuse treatment service
- [ ] Other

If you selected other, please specify

What are the minimum requirements to access programs?(please select all relevant options)

- [ ] Age
- [ ] Signing an agreement / contract as basis for program participation
- [ ] Demonstrating a minimum motivation to participate
- [ ] Cognitive ability to follow the program
- [ ] Good enough knowledge of language
- [ ] Fulfilling the facilitator's requirements for group work (if group work is conducted)
- [ ] Lack of addiction to alcohol or drugs
- [ ] Lack of severe mental disorders
- [ ] Degree of limited confidentiality (e.g. against victim/survivor, referring institutions)
- [ ] Other

If you selected other, please specify

_____

If you selected age, please specify minimum age (N.B. If you run programs for both adults and minors, please specify different age requirements for each)

_____

Intake/assessment phase

- ◯ No intake / clearing phase
- ◯ Only initial interview
- ◯ Individual counselling phase before group work

Are programs rolled out in group settings or 1-1(please select all relevant options)?

- [ ] 1-1
- [ ] Group

What are your facilitation arrangements for 1-1 sessions?

- ◯ 1 male facilitator
- ◯ 1 female facilitator
- ◯ Male team
- ◯ Female team
- ◯ Mixed team

What are your facilitation arrangements for group sessions?

- 1 male facilitator
- 1 female facilitator
- Male team
- Female team
- Mixed team

If there are any substantial differences in facilitation arrangements between programs for different service users, please specify them here

_____

If you selected team above, please indicate the number of facilitators

- 2
- 3-4
- >4

Frequency of 1-1 sessions

- Weekly
- Twice a week
- Fortnightly

Frequency of group sessions

- Weekly
- Twice a week
- Fortnightly

If there are any substantial differences in frequency between programs for different service users, please specify them here

_____

Duration of 1-1 sessions (in minutes) - please distinguish between different service users, if applicable

_____

Duration of group sessions (in minutes) - please distinguish between different service users, if applicable

_____

What is the duration of 1-1 programs?

- up to 3 months
- up to 6 months
- up to 1 year
- 1-2 years
- No time limitation

What is the duration of group programs?

- ( ) up to 3 months
- ( ) up to 6 months
- ( ) up to 1 year
- ( ) 1-2 years
- ( ) No time limitation

What is the framework of group work?

- ( ) Open (rolling) groups
- ( ) Closed groups
- ( ) Both

If you selected 'both', please elaborate

_____

If there are any substantial differences in group frameworks in groups for different service users, please specify them here

_____

Average number of group participants

- ( ) 2-5
- ( ) 6-10
- ( ) >10

If there are any substantial differences in average number of group participants in groups for different service users, please specify them here

_____

Do you run (please select all relevant options)

- [ ] Adult male only groups
- [ ] Adult female only groups
- [ ] Adult same sex groups
- [ ] Groups for male minors
- [ ] Groups for female minors
- [ ] Groups for parents/relatives
- [ ] Other

If you selected other, please specify

_____

What are the main topics/modules addressed in the groups? Please distinguish between the contents of different groups selected, if necessary and relevant

_____

If you have any additional comments to add to this section on secondary prevention work, please do so here

E. Tertiary prevention

Tertiary crime prevention deals with actual offenders and involves intervention in their lives in such a fashion that they will not commit further offences

In which setting does your organization offer tertiary prevention programs?

- [ ] Prison
- [ ] Community
- [ ] Other

If you selected other, please specify

Who are the main beneficiaries of such programs ? (please select all relevant options)

- [ ] Adult male inmates
- [ ] Adult female inmates
- [ ] Former adult male inmates
- [ ] Former adult female inmates
- [ ] Adult males on probation
- [ ] Adult females on probation
- [ ] Male minors who committed child sexual abuse
- [ ] Family members/relatives of adult inmates (male or female)
- [ ] Parents of minors who committed child sexual abuse

How do service users access programs? (please select all relevant options)

- [ ] Referral by police
- [ ] Referral by professionals working in prison
- [ ] Referral by courts
- [ ] Referral by social and welfare agencies
- [ ] Referral by victim services
- [ ] Referral by child protection services
- [ ] Referral by alcohol and substance abuse treatment service
- [ ] Referral by probation
- [ ] Other

If you selected other, please specify

What are the minimum requirements to access programs?(please select all relevant options)

- [ ] Age
- [ ] Signing an agreement / contract as basis for program participation
- [ ] Demonstrating a minimum motivation to participate
- [ ] Cognitive ability to follow the program
- [ ] Good enough knowledge of language
- [ ] Fulfilling the facilitator's requirements for group work (if group work is conducted)
- [ ] Lack of addiction to alcohol or drugs
- [ ] Lack of severe mental disorders
- [ ] Degree of limited confidentiality (e.g. against victim/survivor, referring institutions)
- [ ] Other

If you selected other, please specify

_____

If you selected age, please specify minimum age (NB. If you run programs for both adults and minors, please specify different age requirements for each).

_____

Intake/assessment phase

- ◯ No intake / clearing phase
- ◯ Only initial interview
- ◯ Individual counselling phase before group work

Are programs rolled out in group settings or 1-1(please select all relevant options)?

- [ ] 1-1
- [ ] Group

What are your facilitation arrangements for 1-1 sessions?

- ◯ 1 male facilitator
- ◯ 1 female facilitator
- ◯ Male team
- ◯ Female team
- ◯ Mixed team

What are your facilitation arrangements for group sessions?

- 1 male facilitator
- 1 female facilitator
- Male team
- Female team
- Mixed team

If there are any substantial differences in facilitation arrangements between programs for different service users, please specify them here

_____

If you selected team above, please indicate the number of facilitators

- 2
- 3-4
- >4

Frequency of 1-1 sessions

- Weekly
- Twice a week
- Fortnightly

Frequency of group sessions

- Weekly
- Twice a week
- Fortnightly

If there are any substantial differences in frequency between programs for different service users, please specify them here

_____

Duration of 1-1 sessions (in minutes) - please distinguish between different service users, if applicable

_____

Duration of group sessions (in minutes) - please distinguish between different service users, if applicable

_____

What is the duration of 1-1 programs?

- up to 3 months
- up to 6 months
- up to 1 year
- 1-2 years
- No time limitation

What is the duration of group programs?

- ( ) up to 3 months
- ( ) up to 6 months
- ( ) up to 1 year
- ( ) 1-2 years
- ( ) No time limitation

What is the framework of group work?

- ( ) Open (rolling) groups
- ( ) Closed groups
- ( ) Both

If you selected 'both', please elaborate

_____

If there are any substantial differences in group frameworks in groups for different service users, please specify them here

_____

Average number of group participants

- ( ) 2-5
- ( ) 6-10
- ( ) >10

If there are any substantial differences in average number of group participants in groups for different service users, please specify them here

_____

Do you run (please select all relevant options)

- [ ] Adult male only groups
- [ ] Adult female only groups
- [ ] Adult same sex groups
- [ ] Groups for male minors
- [ ] Groups for female minors
- [ ] Groups for parents/relatives
- [ ] Other

If you selected other, please specify

_____

What are the main topics/modules addressed in the groups? Please distinguish between the contents of different groups selected, if necessary and relevant

_____

If you have any additional comments to add to this section on tertiary prevention work, please do so here

---

F. Victim Support

Is victim support provided during your programs (for secondary and tertiary prevention)?

- ◯ Yes
- ◯ No

If you answered yes, how is victim support provided? (please select all relevant options)

- ☐ By my organization, a specific unit/professional that works just with victims
- ☐ By my organization, by the facilitator/s of the perpetrator program
- ☐ Through partnership with external organization/s that work/s with victims

When is the victim/survivor contacted? (please select all relevant options)

- ☐ When the service user begins the program
- ☐ In the course of program implementation
- ☐ At the end of program

What is the purpose of the contact with victim/survivor? (please select all relevant options)

- ☐ Information about the program and its contents
- ☐ Information about specific working methods
- ☐ Information about limitations of the program (no guarantee for non-violence)
- ☐ Information about legal options
- ☐ Information about the importance of safety measures
- ☐ Information about specific victim services (e.g. victim's support services, shelters, services for refugees or migrants, counselling services for victims etc.)
- ☐ Partner (victim/survivor) experience of violence (their view on violent acts)
- ☐ Partner (victim/survivor) emotional support
- ☐ Assessment of the risk of violence and safety planning
- ☐ Evaluation of the program
- ☐ Other

If other, please specify

Is the victim/survivor informed in crisis situations and warned about risks?

- ◯ Yes
- ◯ No

How is the coordination with the victim support service/units/professionals managed?(please select all relevant options)

- [ ] Joint planning and decision making
- [ ] Case-oriented exchange of information: regularly
- [ ] Case-oriented exchange of information: if required
- [ ] No coordination
- [ ] Other

If other, please specify

_____

What information is exchanged with the support service/unit/professional?(please select all relevant options)

- [ ] Repeated abuse by client
- [ ] History of violence
- [ ] Information about risk
- [ ] High-risk situation
- [ ] No information is exchanged

In cases where victim/survivor is still a minor, which specific approaches, different from/additional to the ones detailed above, do you use?

_____

If you have any additional comments to add to this section on victim support, please do so here

_____

G. Quality Assurance/Documentation/Evaluation

Which of the following measures of quality assurance do you have? (select all relevant options)

- [ ] Team sessions
- [ ] Supervision
- [ ] Continuing education of staff
- [ ] None of the above
- [ ] Other

If other, please specify

_____

What documentation and reporting system do you have? (please select all relevant options)

- [ ] Standardized documentation of clients' demographic data
- [ ] Case-oriented, standardized documentation of work
- [ ] Case-oriented, non-standardized documentation of work (notes etc.)
- [ ] Annual activity report
- [ ] Annual statistics
- [ ] Other
- [ ] None

If other, please specify

_____

Do you measure the outcome of your work?

- ◯ Yes
- ◯ No

If you selected yes, at which stage? (please select all relevant options)

- [ ] When client finishes the program
- [ ] At first follow-up, after finishing the program
- [ ] At second follow-up, after finishing the program
- [ ] Other

If you selected at first follow-up, please indicate number of months:

_____

If you selected at second follow-up, please indicate number of months:

_____

If you selected other, please specify

_____

What outcome do you measure for child sexual abuse? (please select all relevant options)

- [ ] Service user's self-assessment by interview
- [ ] Service user's self-assessment by questionnaire
- [ ] Facilitator's assessment of client by psychological inventory
- [ ] Facilitator's assessment of client by other questionnaire
- [ ] Facilitator's assessment of client using internal documentation and minutes
- [ ] Victim/survivor's assessment by interview
- [ ] Victim/survivor's assessment by questionnaire or inventory
- [ ] Assessment involving family members
- [ ] Official reports (police, court etc.)
- [ ] Other

If other, please specify

_____

If you measure outcome in relation to victims/survivors who are still minors, which instruments do you use that are different from/additional to the ones detailed above?

_____

If you have any additional comments to add to this section on quality assurance/documentation/evaluation, please do so here

_____

Is there anything else that you'd like to add?

_____

Thank you for completing this questionnaire!

_____